

Review of the National Mental Health and Suicide Prevention Agreement

TRANSCRIPT OF PROCEEDINGS

O/N H-2045719

PRODUCTIVITY COMMISSION PUBLIC HEARING

MR SELWYN BUTTON, Commissioner
DR ANGELA JACKSON, Commissioner

DAY ONE

TUESDAY, 19 AUGUST 2025

MR BUTTON: Good morning, everyone. Thanks for joining us online today and welcome to the public hearings for the Productivity Commission's review of the National Mental Health and Suicide Prevention I would like to start by acknowledging the traditional custodians of the land that we are meeting today and pay respect to their ancestry and custodianship of this country. We're coming to you today from Melbourne in Narrm on the lands of the Wurundjeri people of the Kulin Nation. My name is Selwyn Button. I'm a commissioner with the Productivity Commission. And today, with my fellow commissioner, Angela Jackson, we're leading this public inquiry.

The purpose of these hearings is to facilitate public feedback and comment on the recommendations that we make in our interim report, which was released in June. Following our public hearings, we will be working to finalise the report and hand it to government in October, having considered all the evidence that has been presented at the hearings, the submissions that we receive in relation to the interim and further analysis undertaken from the inquiry. Participants and those who have registered their interest in the inquiry will be advised of the final report's release by the Australian Government, which may be up to 25 Parliamentary sitting days after we hand it to them.

We are grateful to all the organisations and individuals who have taken the time to meet with us, to prepare submissions and to appear at these hearings. We like to conduct all the hearings in a reasonably informal matter, but I remind participants that the sessions are being recorded and a full transcript is being taken. For this reason, comments from observers cannot be taken. But at the end of today's proceedings, I will provide an opportunity for anyone who wishes to do so to make a brief presentation. Participants are not required to take an oath but are required, under the Productivity Commission Act, to be truthful in their remarks.

Participants are welcome to comment on the issues raised in other submissions. The transcript of today's proceedings will be made available on the commission's website. The chat function and reactions are turned off for today's proceedings. The review team will use the Q&A function to provide information. If you want to contact the review team, you can post a question in the Q&A, which only you and the team can see, or you can email the address provided in the Q&A. We wish to advise that this hearing is open to members of the public to observe. For people who are observing, your microphone and camera will be turned off by the project team.

Presenter's microphones and cameras will be enabled by the team when it is their time to present. For any media representatives attending today, some general rules apply. There's no broadcasting of proceedings allowed, and taping is only permitted with prior permission. Members of the media should also email the address provided in the Q&A, who can provide them with further information. Participants should be aware that media representatives may be present, may be using social media and other internet mechanisms to convey information online in real time, including participant's remarks. We have a counsellor, Natasha Belmont, from Relationships

Australia, Victoria, with us today for anyone who would like to chat or needs some additional support.

5 If you would like to speak to Natasha, please email the address provided in the Q&A or use the Q&A function to send a message to the team. People appearing in an individual capacity today will be automatically allocated to a breakout room with Natasha after their appearance is concluded. I would now like to welcome our first presenter, who is Sam Harvey from Black Dog Institute.

10 PROF HARVEY: Hello there.

MR BUTTON: how are you going?

15 PROF HARVEY: I'm fine. Thank you. Apologies for that delay. It was just taking a while for them to give me control of my microphone.

20 MR BUTTON: That's okay. Just part of the wonderful technical glitches that we're going to have during the day, where there's going to be a little bit of a delay between when we – when I announce who's coming on and then when you turn up on the screen. But what I will ask you to do – and I will ask everyone to do it when they first start – is if you could actually say your name, your title and your organisation just for the recording as well, and then we can get into your first statement.

25 PROF HARVEY: Great. My name's Professor Samuel Harvey. I am the executive director and chief scientist of the Black Dog Institute, and a professor of psychiatry at the University of New South Wales. Just want to acknowledge that I'm calling in from Sydney, so I'm on land where the traditional owners are the Bidjigal clan of the Dharawal Nation, and I want to add to your earlier comments about extending respects to elders, past and present.

30 MR BUTTON: Thank you. Now, the Black Dog Institute has provided a submission. What we want to be able to do is to give you the time to talk through your submission and to focus on the key points, I guess, in your submission that you would like to bring to the attention of the public hearing. So I will give you the time.

35 As I mentioned, the time we have allotted for each presenter is 15 minutes. So if you can talk through your bits, we will actually ask some questions throughout the process, but certainly, if there's some clarifying pieces, then we can – we will – Angela and I will come to and fro with you as well.

40 PROF HARVEY: Wonderful. Well, look, thank you so much for the opportunity to present to you and also for the work that the Productivity Commission has been doing around mental health reform, not just in terms of the work you're doing currently, but obviously, the work you did around mental health in Australia a number of years ago. It has proved to be of a lot of assistance in terms of us trying to

45 move forward with mental health reform. Just by way of background, Black Dog Institute is the only medical research institute in Australia that considers mental

health across the lifespan, and we want to participate in this review for two key reasons.

Number 1, we know that mental ill-health is one of the great challenges of our time.
5 We have data here in Australia that is showing we have increased rates of depression, anxiety, increased presentations for self-harm amongst adolescence and young adults in Australia, and it's getting worse, year on year. So the need for action has never been greater, and as a medical research institute, we firmly believe that the best way that Australia can turn the tide on what we're seeing in mental health is to use the
10 best available research evidence, combine that with the voice of people with lived and living experience to create great policy.

We want to commend the interim report of the Productivity Commission. As outlined in our submission, we agree with a great deal of what was said in that.
15 Crucially, we would agree that – with, I suppose, the central finding of the Productivity Commission that the national health – mental health and suicide prevention agreement hasn't proven to be an effective mechanism for improving the mental health of Australians. We would agree with the comment of the Commission that some aspects of the agreement have been really commendable. We would also
20 agree that there is an urgent need to get coordination between state and federal governments, but the current wording of the agreement hasn't provided that.

We would agree that the new agreement does need greater accountability, does need much clearer deliverables, much clearer targets, much clearer specification of what is
25 required from the different signatories. Where we differ from that headline finding of the Productivity Commission is around the timeline for developing the new agreement. We agree that time is needed to make sure that we get this right, but what we would say is that there's a once in a generation opportunity to do this right now, where we have agreements being formed around the NDIS, we have the
30 National Health Reform Agreement in negotiation, and so we would argue that now is the perfect time to be drafting the new mental health and suicide prevention agreement.

And we would respectfully ask whether the Commission was able to look at the date that they set for the new agreement and, I guess, challenge both government and the
35 sector to whether we can bring that forward so that the new agreement can start sooner than proposed in your interim report. The other things which I was hoping to highlight – I mentioned at the start Black Dog Institute is a mental health research institute, and one of the things we wanted to highlight in our presentation today is
40 that we stand on the cusp of some hugely exciting developments around mental health prevention and treatment. For the first time in a number of decades, we have new treatments coming through the research pipeline that are proving to be transformative in the way that clinicians like myself manage mental health conditions.

45 An example but not the only example of that is ketamine, psychedelic assisted therapy, some of the new digital treatments that are available. When I see patients in

the clinic, each week I'm reminded of how, when used correctly, these new research led discoveries can transform people's lives. Even if we think about prevention, we are now at the point where research is beginning to show us how we might be able to prevent mental health problems from occurring by doing the right things in schools and in workplaces. The reason why I say all of this is because I think, at the moment, the national mental health and suicide prevention agreements have been relatively silent about research and the role that research should be able to play moving forward.

And over the course of the next agreement, there is a real opportunity to transform the way in which we're able to prevent and treat mental health but only if we use research in the right way. And what we would like to see is a schedule for research and innovation in the new agreement that outlined three things. Number 1, outlined the role of the different signatories for funding research and ensuring that research into mental health receives its fair share of funding.

We, at the moment in Australia, we have the situation where mental ill-health is the number 1 reason people are walking through the door to see their GP, the number 1 cause of death amongst young Australians, yet it does not receive its fair share of research funding, and there's a role within the agreement to be able to correct that. Number 2, if there's a schedule within the agreement, it provides an opportunity for the nation to be able to define the types of research questions we need to be answering in mental health, and the role of State and Federal Government in doing that; and, then, thirdly, it allows all players and signatories to think about getting the pathways right so that the research findings can be translated quickly into better clinical care, and in our submission to the Productivity Commission, we go into a little bit of detail about the pathway that ketamine treatment has followed in Australia, because it highlights the current bureaucratic burden of transforming new research findings into better treatments for patients, whereby, because of the rules and the way in which new medicines are regulated in Australia, we're in the situation where Australia has led the world in discovering the potential of ketamine, yet most patients in Australia cannot access it, and so we would argue that within the research and innovation schedule, these types of barriers needs to be addressed.

The third point I wanted to highlight was the critical role of building Australia's mental health and suicide prevention workforce. We're lucky, in Australia, that we have a framework for what needs to happen for our mental health workforce. What hasn't been achieved under the previous agreement, as noted by the Commission in the initial report, is that that hasn't actually been actioned, and we face a situation now, across Australia, where there are long waiting lists to see a mental health professional where we have inadequate mental health staff to meet the needs of Australians, and so within the new agreement there needs to be a commitment to build that workforce, to build all parts of the workforce; traditional roles, like psychiatrists and psychologists, as well as some of the really important new roles, such as a peer workforce.

We agree with the recommendation to – that the new agreement should provide greater clarity around the essential role of peer workforce within multidisciplinary teams, but it should also lock in commitments from both – all levels of government around the extra funding and the policy initiatives that are going to be required to
5 ensure that we have a workforce to manage the mental health conditions we’re seeing in Australia, because, at the moment, there’s just not the funding, and there haven’t been the policy initiatives to ensure that.

10 The final point I wanted to make in my allotted time was regarding the potential for digital interventions to improve both access and availability of mental health care in Australia. This is another area in which Australia has really led the world in doing the research about showing the potential of digital products, but where we have fallen down in translating that into the services that people across Australia are able to use. There’s huge potential for AI to help with system navigation and greater
15 efficiency.

There’s great potential for things such as blended care to ensure that we get as much return on investment from the new workforce we talked about building, but, at the moment, the agreement – previous agreements have been relatively silent on both
20 regulation around digital initiatives, and also how we can shift away from the outdated ways in which we fund clinical services to enable us to access digital – the current Medicare item numbers, the current activity-based funding doesn’t really incentivise services to make the best use of digital technology, which means we’re not able to get as much help out to people as we could otherwise be doing.

25 There were some other points made in our written submission around, really, endorsing some of the recommendations made in the interim report around the inclusion of a schedule for First Nations people and their social and emotional wellbeing around a schedule for suicide prevention, but I think, in the interests of
30 time, and seeing as we’re largely agreeing with the interim recommendations with a few comments around that, I won’t bother going through that, and leave some time for questioning.

MR BUTTON: Thanks very much. Really appreciate that. I do want to get into
35 some questions now, and probably the first one, going back to your first comment in respect of the delay in the agreement, and so wanting to delve into that a bit further, purely because, I guess, from what we’ve heard through the process to this point, is that there’s the lack of a national strategy, and the last national strategy that was brought together was in 2008, and so that’s why we’ve sort of gone down the path of
40 looking at posing that as a recommendation to develop a new strategy, because we think that if we have a long-term vision and a long-term strategy, it provides an anchor point for five-year agreements. So if we have a longer-term 20 to 30 year vision, an anchor point can be what’s achievable through an agreement in five years, and I guess I wanted to posit that to pose to you, okay, well, here’s why we’ve –
45 here’s what we’re thinking; this is what we’ve heard in previous conversations throughout, I guess, the sector itself, and put that in – get some reaction from yourself,..... you’re talking about no-delay and a focus on the opportunity now,

whilst there's negotiations about – around the NDIS and what's happening in psychosocial support, what's happening in the National Health Reform Agreement to seize on that opportunity. So I wanted to get some reactions to that - - -

5 DR JACKSON: Yes, yes.

MR BUTTON: - - - to that comment.

10 PROF HARVEY: And, look, I absolutely endorse the view that Australia would benefit greatly from having a national strategy that's driving what's happening around mental health reform and the day-to-day provision of mental health services. The problem is, for me – and my concern – is the risk of if we put agreement around that strategy as a necessary step before we have a national agreement – and I guess I have sat around enough meetings where we've been trying to get a national strategy
15 to know how difficult that can be; that's not to say we shouldn't do it; we absolutely should. I suppose my question back would be would it be possible to reverse the order of that and to have an agreement set in place so that we can begin to fix some of the massive gaps in service provision to people in Australia suffering from mental ill-health, but have all parties coming together to set that much longer viewpoint of a
20 strategy as one of the first deliverables under that agreement, because the reality is the strategies you describe is going to be looking through a lens of where do we want to be in 10, 20 years' time?

The agreement is going to cover a shorter period of that, so it sort of strikes me that
25 that could be something that was done as a deliverable of the agreement rather than a prerequisite to the agreement, and I guess, you know, speaking frankly, there are those of us who have been advocating around mental health reform for a long time have heard many times we're one inquiry or one agreement away from really meaningful reform, and we – the sense is now that there is political, public sentiment
30 that we need action now, and the idea of everything being on hold while we go through this process of further consultation, makes me concerned about not just the individuals who miss out while we're going through that process, but, as a nation, the momentum we will lose in doing that.

35 MR BUTTON: Okay. Well, that seems sensible. I'm going to go to your next one.

PROF HARVEY: Yes.

MR BUTTON: Unless anyone wants to - - -
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DR JACKSON: No, you go, that's fine. I will jump in briefly at the end of my - - -

MR BUTTON: We're going to go to the next comment in relation to looking at a proposed new schedule around research and evaluation, and, as you would have read
45 in the interim report, our suggestion is that we focus on ensuring that there is an evaluation that occurs of all initiatives that are funded under the agreement - - -

PROF HARVEY: Yes.

MR BUTTON: - - - and that you the bilateral arrangements, and those evaluations are made available to the public, because what we want to make sure is
5 that the evidence suggests that what's been funded through the agreement is not only publicly available, but it's the best evidence - - -

PROF HARVEY: Yes.

10 MR BUTTON: - - - to support improving outcomes, but you're wanting to take it a step further.

PROF HARVEY: Correct, and, just to be clear, I could not agree more strongly with those recommendations. I feel there has – it has been a huge oversight in
15 Australia that we have rolled out new initiatives at scale, and then thought about evaluation afterwards, and then there has been limited access to some of the evaluation. So I think evaluation of services, particularly of new services and the public availability of that is absolutely crucial, and I was delighted to see that in the report.

20 What we're suggesting is, yes, something in addition to that, and looking more upstream. So yes, we want to be evaluating what's being rolled out in the community at the moment. What we're saying is the - where the real breakthroughs in mental healthcare are going to happen is making sure that we've got the right
25 research going on into new treatments and new prevention.

And the signatories of the national agreement in terms of the State and Federal Governments all have a role in that, and what we would love is for the agreement to articulate that commitment, ideally even quantify the commitment in terms of what is
30 needed to terms - to actually do the research to try and solve the problem and to also ensure that there's two other - you know, number (1) guidance around what are the most important research questions for Australia to be funding researchers to be answering, and there's a role, obviously, for organisations like ourselves and others to be providing advice around that, but also making sure that we don't allow great
35 research to just remain on a shelf or to be used in other countries to make great services there, that that's getting pulled through and given to patients straight away.

MR BUTTON: And so the idea then that the schedule and what priorities - research priorities are defined in the schedule are then also used to influence, if you like,
40 research grants from research - those that commission research in terms of the research that they're undertaking in mental health, suicide prevention space that actually influences what research they're funding as well.

PROF HARVEY: Exactly. Yes. We - you know, what that - it - that it influences, yes, what research funding in terms of the quantum of research funding as part of the
45 agreement, saying, "This is the size of mental health problem in Australia. This is what we think is needed to try and solve it," and also, yes, what are the questions that

are most important for what we're trying to achieve in terms of new treatments, new models of care, things like that.

5 MR BUTTON: Okay. And in quantifying what that might look like through the schedule.

10 PROF HARVEY: Exactly. And, you know, of course, you know, these things change over five years. You know, my hope is that the research over the next few years is going to bring about some really exciting new things, so part of it might also be putting in place a structure so that that can be updated as new information comes to light, and that you have - you know, that we as a country can know that we're bringing together the best minds around this problem to guide where the - you know, what are the topics that our national institutions are funding research into.

15 MR BUTTON: Okay. You also speak about your digital mental health services.

PROF HARVEY: Yes.

20 MR BUTTON: Talk a little more about that.

PROF HARVEY: And this is - because I feel - I think - - -

MR BUTTON: understanding - - -

25 PROF HARVEY: Yes.

MR BUTTON: what we're trying to work out here, and what I'm trying to tease out, without leading you, to talk about that, so really - - -

30 PROF HARVEY: Yes.

MR BUTTON: It was really who's the audience and what's the uptake of the audience in the digital services that you're describing?

35 PROF HARVEY: Yes. So - and that has been one of the key problems to date, in that we have had over many years an accumulation of evidence around the power of digital technology to help with providing both prevention and treatment services. But digital services have largely been decoupled from all of the regular services that are captured within the agreement.

40 So both State and Federal Governments do provide some funding for digital mental health services, but it's not at all integrated with the other funding that goes on, and so you can have a situation where an individual might go, you know, see a psychologist. A psychologist might suggest using a digital product as part of the treatment, but that digital product isn't captured at all within any of the national agreements. There's no Medicare item number around it. It might be funded by a

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totally separate grant from a Federal or State Government or it may be a private company providing it.

5 And so it just creates disjointed, non-regulated stuff, and so there's some amazing examples of where digital products are helping services be much more efficient, but then there is also a lot of nonsense out there, and I think it's very hard for consumers or clinicians to be able to tell them apart and to integrate it properly into the treatment.

10 DR JACKSON: I'm conscious of time, Sam. Is there anything final you'd like to say before we need to wrap up and - sorry, I did have some further questions, but we're just getting used to this tight timeline of the - - -

15 PROF HARVEY: Well and of course, you know, no one is more waffly than an academic psychiatrist, so I apologise for that. I think the final point I would make is just to reiterate the centrality of the workforce question in mental health reform, and there's no point opening up new buildings, new services if we don't have staff to staff them, and that intersection between the State and Federal Government is absolutely crucial to get that right, and I think that has been one of the biggest
20 problems over the last decade, and it would be a tragedy if the new agreement didn't try and solve that.

DR JACKSON: Thank you very much.

25 MR BUTTON: Really appreciate your time today, Samuel.

PROF HARVEY: Thank you so much.

MR BUTTON: Thanks very much for your submission - - -

30 PROF HARVEY: Thank you.

MR BUTTON: - - - and thanks for your appearance.

35 PROF HARVEY: My pleasure. Thank you.

DR JACKSON: I believe next we have Bronwen Edwards from Roses in the Ocean.

40 UNIDENTIFIED MALE:

MS B. EDWARDS: Morning. Okay. Just got access to the camera and audio. I also have Simon Pont with me. He is on his own laptop. Do you need us to be on the same screen?

45 MR BUTTON: No, that's okay. That's okay. It all depends, I guess. Are you guys sitting in the same room?

MS EDWARDS: Yes.

MR BUTTON: It might be easier just to use the one laptop, because purely with the tech piece, we'll then need to let him in, etcetera - - -

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MS EDWARDS: Okay.

MR BUTTON: if you - - -

10 MS EDWARDS: All good.

MR BUTTON: If you can - if you both - whether or not you can fit in the camera together or you need to swing it around - - -

15 MS EDWARDS: all good.

DR JACKSON: Perfect. Thank you very much.

20 MR BUTTON: Makes it a lot easier - because as you would have seen, when we switch from camera to camera, there is a bit of a delay, and makes it easier if you guys are sitting in the same room and on the same camera. That'd be great. So thank you very much for joining us today, Bronwen and Simon.

25 Look, I failed as the host of this thing at the beginning because I gave the wrong time period for - when we started I'm going to give you guys the right time period this time. You do have 30 minutes, not 15 minutes, as I said, but what we will do is give you five minutes to start in terms of providing an opening statement and then we'll get into asking questions and getting you guys to focus on a few of the things that you want to point out in your submission.

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MS EDWARDS: Wonderful. Thank you. Thank you very much. So we really appreciate the opportunity to speak with you today and just, you know, delve a bit deeper in some of the issues that we raised in our submissions with you. We are a national organisation representing people with the lived experience of suicide, and so we bring to this discussion that very nuanced, lived experience lens to, you know, a range of topics and what have you.

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40 So very interested to speak with you today about some key areas around governance and just ensuring equality of voices - equity of voices, rather, in the representation. Peer workforce obviously is an area that we are involved in in a range of different contexts, so interested to share some of our insights a bit more deeply there.

45 And also interested in broadening that conversation around the suicide prevention system broadly speaking and the opportunity that the national agreement provides us in terms of expanding that ecosystem of services that would then, we believe, make it a lot easier for people to have choice and autonomy around the types of supports that

people on the ground are asking us for. So that's really the context of what we'd like to bring to the discussion today.

MR BUTTON: Excellent.

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MS EDWARDS: Thank you.

MR BUTTON: Sounds very good. And what I will do is – what I should have done at the beginning is also ask you to say your name and your title when you're starting the process so at least for the transcript, we can identify who's speaking at certain times as well.

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MS EDWARDS: That makes perfect sense and would have made sense for me to do that as well. So I'm Bronwen Edwards, and I'm the CEO of Roses in the Ocean.

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MR PONT: And Simon Pont. I'm a general manager for reform at Roses in the Ocean.

MR BUTTON: Excellent. Thank you. Simon, did you want to open with a few comments as well? - - -

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MR PONT: I think certainly as Bronwen has touched on, the point around lived experience of suicide representation in governance forums, and we made this in the submission. Certainly the interim report can be really commended for providing a focus around lived experience representation, in particular lived experience expertise, but, as you'll note in our submission, we have suggested an amendment to that draft recommendation 4.7, and, in particular, whilst we – certainly and would advocate for a place for consumer and carer representation, I would also advocate for and suggest consideration is given to lived experience of suicide representation in these governance forums as well, and certainly Roses in the Ocean has played a part in that space and certainly which suggests there's a role to play moving forward for the next agreement.

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MR BUTTON: Thank you. Now we can get into some questions.

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MS EDWARDS: So – and I'm just wondering if it might be useful for us to just put a bit more context around what Simon was just talking about, just to understand the differences that we see on the ground and within lived experience. Would that be helpful for you as a starting point?

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MR BUTTON: That'd be great, because where you've touched on in your submission to focus on amendments or altering the recommendations to add a bit more meat to the bone, if you like, certainly governance is one of those things that we've seen as something that we want to focus on through this arrangement, and you've touched on the governance arrangement here, so it'd be good to tease it out a bit and what that then looks like in terms of those bolstering of recommendations.

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DR JACKSON: It'd also be good just to draw on your experience for the public record what works, when it works and why it works. So I think often, you know, lived experience and the inclusion of it in a meaningful way is often seen – I'm not – from a bureaucratic perspective, as well, “This is a lot of work. What's the point of going through this?” And I think just for you to articulate why that is so important and where you've seen it working from your experience would be really helpful for us, too.

MR PONT: Yes, there's some really good points, but I think certainly the experience of people that we work with who have a lived experience of suicide who sit on those governance forums at various levels of government, but also in advisory groups, is that, to your point, it is often perceived as being tokenistic. There's a challenge in terms of that decision-making that the lived experience expertise is not valued alongside evidence base or professional roles.

And certainly where we have seen it work is in areas where there's been both a selection of a diverse representation of people with lived experience, but also, as highlighted in the national suicide prevention strategy, worked with the organisation to ensure that they are able to engage people with lived experience, provide space for them in their decision-making and ensure that the lived experience principles and why lived experience brings such a valuable voice and expertise to that conversation is – should be part of the conversation.

Certainly I think we know, and there's been research that highlight this, that when that lived experience expertise is involved in decision-making from design, implementation and evaluation, the outcomes are far better. When the people who are directly impacted by the decisions that are made at a policy level through to service delivery - if they're engaged at the start, the outcomes are far better.

What we would suggest, though, is that there needs to be a recognition of the consumer and carer voice who come from that perspective of mental health challenges, and certainly the newly established peak bodies do a fantastic job of representing that consumer and carer voice, but not everybody who has a lived experience of suicide comes from that mental health challenges perspective. Others have a lived experience of suicide due to situational distress; some have social determinants and commercial determinants of suicide. And we potentially are missing out of half the population of lived experience voices if we only focus on consumer and carer perspectives.

As I said, they have a role to play and - an important role to play, but we would suggest there's an opportunity for, alongside those two newly established peak bodies, to also have the lived experience of suicide voice included and certainly, as part of a national suicide prevention and leadership support program, Roses in the Ocean, alongside the Indigenous Australian Lived Experience Centre, are funded to provide that lived experience leadership. And in the last agreement, we were involved in the lived experience service guidelines for aftercare for postvention and

distress brief support, so working with people with lived experience to design those service guidelines.

5 And so I think there's certainly things we can build on from the last agreement, but also I think there's opportunities for improvement and opportunities to highlight those areas of where it's working well, but also identify the barriers of why partnership and inclusion of lived experience is not occurring in those governance forums.

10 MS EDWARDS: Yes. And if I can just add to that, as well, just to go back to the question around, like, what works well and what do we need for it to work well, I think it's really fair to say, you know, over the last 10 years and more specifically probably the last seven or eight, there has been that much, much better intent, a real growing desire, to include people with lived experience. And it's true it's been a
15 bumpy road at times.

There's been an awful lot learnt in terms of what do we need to do to support everyone who comes to the table. It used to be thought that you just had to support the people with lived experience because we were vulnerable and fragile, and we
20 know that that's not the case. People who are engaging people with lived experience need the suicide literacy, need the support as well to be exposed to more lived experienced stories.

So it is a holistic approach in terms of how does everybody work well together?
25 How do you equip the people with lived experience to learn how to bring not just their story but to bring really key insights and messages and things that are going to be impactful that can actually drive reform and bring their particular experience but also be able to bring that into the context within which they're being engaged? A lot of work has been done by us and others over the years in terms of really helping to
30 bring the expertise of someone with lived experience because there is a difference, and you do over time develop an expertise of how to bring that experience into, as I say, different contexts.

And for some people, that will be data is their thing or policy is or service design or
35 all sorts of roles, and it's about continuing to develop the lived experience of suicide workforce, and that is those people who will sit on advisory groups, who will take lived experience designated roles in government departments and sector organisations. Building that expertise and continuing to do that.

40 It's also about making sure that when they're entering into an advisory group or an organisation, that they're actually provided with the context and background that they need so that they can actually contribute meaningfully and ensuring that they're not one of only one or two people sitting on a group amongst a whole other group of people where there is a real perceived power imbalance because that can really
45 impact how comfortable people feel in contributing.

And then, of course, you've got the peer workforce side of things, as well, which I know we're going to come to in a moment, but it is about wrapping around organisations to help them and the culture change they require to embed this voice really meaningfully, and it's about wrapping around ongoing development to bring
5 lived experience people along and develop their expertise to be involved in all sorts of roles.

MR BUTTON: And I was going to go to the peer workforce component, Bronwen, because this in – there is a bit of a balance there, in the sense that when we look at
10 training for the peer workforce and upskilling the peer workforce, and, as suggested in the interim report, what we're describing or talking about is whether or not we should go down the path, through the next agreement, of developing a scope of practice for the peer workforce so that the broader workforce and the broader organisations where peer workers are being placed, have a better understanding of
15 their role and how they interface with those sorts of things, but you've talked about training. Is there – are there examples of training that are working well at the moment and, certainly, when we look at some comparisons of industries in the health industry, we think about Aboriginal health workers, we also think about what happens in drug and alcohol services spaces where there are peer workers,
20 essentially, that are working in those spaces to then – and they've professionalised those workforces. What – is that something that you think is needed or a step that we should be thinking about in the future with the peer workforce, or is this a starting point thinking about developing the training that's best suited, to then ensure that the sector gets a better understanding of how to work with the peer workforce?

25 MS EDWARDS: I think in this – like, our view on this is that the horse has bolted, and so all of the things you mentioned really need to be happening in parallel. So there are already people who are being engaged to be a peer worker who have no peer background. They may have just come out of retail or an admin role, and have a
30 lived experience and want to be in that space. And there's no doubt that they may be absolutely wonderful in that space, but they need scaffolding, and support, and professional development, and what have you, but then there's also people who are highly experienced peer workers, and who have, you know, really, the mental health peer workforce and the AOD are probably far more established than a nuanced
35 suicide prevention peer workforce but, of course, there are people with lived experience of suicide from those disciplines of peer workforce as well.

So from our view, it's a number of things in parallel. I mean, there's obviously a lot of work happening at the moment around the peer workforce, standing up a peer
40 force association, and scope of practice, and all of that is really important, and from what we hear from peer workers and our peer workforce team are involved in trying to drive that work, and that – I think what's critical there is that there needs to be this collaboration between all disciplines across peer workforce, because there is a lot of commonality in practice, but then there's a need for nuanced speciality training, and
45 provision of service as well.

In terms of organisation services, everyone is – has – is hearing that lived experience needs to be involved, that peer workforce is incredibly valuable to intersect and complement clinical services, and in some aspects, like the services that we deliver, purely non-clinical peer-led, that they're a role for all these different types of blended
5 workforces and peer workforces, but the organisations need support as well to be able to really truly understand the value of what a peer worker can bring, where it complements, and what sorts of supports need to be wrapped around everyone in the workforce, for that to be sustainable and successful.

10 So there's that organisational development and culture change, there's the framework for everyone, and then there's the training piece for the peer workers themselves, and I think it's pretty well-accepted across the country now that the Cert IV in mental health peer work is not enough. From a suicide perspective, it is only an elective, so
15 people can actually get that certification without having had any formal suicide prevention training. You've also got intentional peer support, which is a good foundational peer-based training, but it comes out of the AOD sector, and once again, doesn't have that specialist suicide context.

Just to speak from our experience. About five years or so ago, we had an
20 opportunity to work within Victoria, and looking at providing suicide prevention peer worker training into services, but what we learnt from that was you've got such great disparity between expertise, in terms – you could have a peer team of four people, and someone with 10 years' experience, and someone straight into it, green with no experience, some with qualifications and others with not, and trying to put a
25 cookie cutter training into that environment doesn't work. You've also got the logistical barriers of people can't – services can't pull all their peer workers out of service in order to do training for extended periods of time.

So what we are doing now – the approach that we've now moved to is to develop a
30 whole suite of individual self-paced learning modules that can be done online, fitting in with different peer rosters. People can meet – they can meet people where they're at in terms of their experience and expertise. There's the foundational sort of work for people who just want to get into peer work, and want to learn the absolute basics and fundamental principles of peer work. Then there's another phase which – that
35 can start extending that, and then there are advanced nuanced modules which are then really appropriate also for any sort of peer worker, from any discipline, so that they can focus in on neurodivergence, for example, or moral injury and distress, or providing support to people from cultural linguistically diverse communities and, of course, you can't cover all of that in one module, but it's – the idea of these is to try
40 and just have bitesize pieces of learning and professional development for peer workers to be able to expand their – or develop their expertise as they go.

So, look, you know, it's new and – but we've looked at what's available and looked at what our clients have asked of us, and this is what – the path that we're going
45 down at the moment and, you know, have a couple of places in Australia where that's now being implemented, which will be externally evaluated to see, is that hitting the mark, and is this actually meeting the needs of peer workers.

MR BUTTON: I was going to ask about your non-clinical roles, because you talked a little bit about non-clinical, and where non-clinical led services are working well. Talk a little bit about where it's working well, and why it's working well, because, again, it's – what we've – through the process, we've heard a lot about – we do hear
5 a lot about and we understand a lot about clinical services, and what happens in clinical settings, but we're wanting to also make sure that there's a significant spotlight on what happens in community-based settings, and the importance of those in the overall, I guess, important process for people that are experiencing suicidality and, certainly, families of those people as well.

10 MS EDWARDS: Yes. Yes, most definitely, and the reason that Roses in the Ocean has expanded our range of work into this space, is because of what we've heard from people with lived experience in community for many years. So there's no doubt that non-clinical peer-led services address a critical gap in existing healthcare systems.
15 We know that – we hear all the time that people are not having great experiences, in many instances very negative experiences going into traditional settings. With Simon's comments earlier around – you know, there is a time for clinical support. There's no doubt about that, and we absolutely recognise that, and there are people who live with mental illness that absolutely require that, but even people with mental
20 illness, it's sometimes they don't need that.

What they're actually seeking is to be able to sit in a space with someone else who has walked in similar shoes, and literally be heard and validated, and have someone where – somewhere to go where, instead of sitting at home in crisis, struggling to
25 decide whether to stay or leave this world, they can go and be amongst others who understand it, and that space can be held for them safely while they – whilst they ride that crisis out. So our – once again, it is in trialling phase, it's – you know, we're into five years now of trialling these different non-clinical peer-led services, and they're all being evaluated externally. Anecdotally, though, and through qualitative
30 evaluations, there is enormous support for these types of services to be available within community.

People are wanting them to be community-led. They need to be localised to community needs. So, for example, with the community-led safe spaces that Roses
35 in the Ocean are supporting communities in the background to establish, that came out of 20 co-designs across New South Wales for what are now called the Safe Havens, which are a blended clinical peer model. What people asked for was that they did want that completely non-clinical space, so that's why we're trialling it. So there's 13 of them around the country now, almost eight or nine of those have
40 managed now to transition to an independent stage, and we will support at arm's length, but the idea is that we work with these communities, such that these spaces can become sustainable, there's collective ownership by community because everyone's invested in it, and what we're hearing from communities now is, not only are these spaces providing a space for someone when they're in distress, or just
45 simply needing that connection, but they're actually starting to change communities in the sense that people are now talking about suicide more than they were.

People are aware that community has a role to play in suicide prevention, because of the presence of a community-led safe space, for example. Other examples are our Peer CARE Companion and community services. They've been in Perth and in Northern Beaches for a number of years, and we're now just establishing three in
5 Queensland and one soon to come to the ACT.

Those peers are in – are on the ground, and they are walking alongside people doing whatever those people require. Now, for some people, that will mean going with them to the supermarket because that's just too challenging. It may be just going for a walk on a weekend because the weekends are hard, and that's when there's a gap
10 between when they can see other services that they access. A lot of the work is around navigating services, which is really difficult to do, even if you work in the suicide prevention sector. It's really hard to find help. There's peers and community. Once again, they've got similar lived experience of people they're supporting, and they're able to navigate where they – where options of support might
15 be.

They can understand what are the causes of that person's distress and then try and seek out the right other services that might provide housing support or financial advice or relationship counselling. So these people are like this golden thread that
20 are able to be in community, walk alongside and then connect them with other services. They're often supporting people who are on waitlists for aftercare services or bereavement support, for example, or providing just that additional layer of support while they are engaged with another service as well. And then the other non-clinical peer-led service that we are trialling is our national and that's not for
25 people in crisis.

So it's a callback service, but it's where people with lived experience can simply connect to others. So if someone has been bereaved by suicide and they're coming up to an anniversary, they can ring us and say, "I really – this is hard this year. It has
30 been 10 years, but it's still really tough. Can I talk to someone who gets it?" And there's that connection that's happening and the peer matching that's allowing us to make that service much more accessible. We're peer matching to not only lived experience but other intersecting experiences and demographics that people deem important for them in terms of who they want to talk to.

35 So it's very promising, and I think it's – the most important message is that it is an "and". It's not meant to replace existing clinical services or other services that are working on the ground, but it's to complement them and supplement them. There's also one last thing, and then I will be quiet. There's also – we're seeing a lot of
40 really wonderful benefits for the people who are actually in those roles because giving back to others is an enormous part of your own growth after, you know, really hard experiences and trauma and what have you.

DR JACKSON: So you went just then, I think, to the importance of education and
45 awareness and, you know, stigma reduction particularly around talking about suicide in the community. There is meant to be a stigma strategy – a national strategy released. Is that an important part of this picture, you think, going forward as well,

that we do have that national approach and a strategy in place more broadly to reduce stigma?

5 MS EDWARDS: I do. I think – and I will be – I will hand to you in a sec. I also
think we've got to call it out for what it is. You know, stigmas are – I think stigma is
a word that can be hidden behind. It is discrimination and prejudice and fear, and we
need to call that out. And so long as a stigma strategy is absolutely imbedded with
lived experience voice because it's lived experience story that will be a catalyst to
change more than anything else. And so if it is centred around lived experience
10 voice of the various areas that need stigma reduction, then absolutely. I'm
completely supportive of that.

MR PONT: Yes. I would agree. And I certainly think what it does do well is go to
a range of those industries that really have a role to play in stigma reduction, so
15 whether it be insurance companies or banks or whatever it might be. The strategy
itself is great. What is also needed is the education component around that. So we
know, in terms of suicide prevention, that there are numerous industries that have an
opportunity for early intervention for people in distress, and the experience of people
with a lived experience is often not being heard or experiencing stigma within those
20 environments community groups are called population groups experiencing
stigma within that.

So there really needs to be that education component, which is what Bronwen's
talking about, in terms of people with lived experience being able to lead education
25 that changes how we view suicide, how we view mental health challenges, how we
view alcohol and other drugs.

MR BUTTON: Conscious of time, but certainly, I guess, Bronwen, what I wanted
to get to in a sense of getting to describe some of your non-clinical services and so
30 the safe spaces themselves is really to highlight that there's a – there is a significant
role for community-based services in the prevention end. And it is very much about
complementary. It is about not either/or, it's an "and". But certainly, looking at the
work you guys have done and what happens in that safe space that there's – there
are some good things to come out to focus on prevention and what we can see in
35 some preventative activities that are part of what might be a new agreement as well.
So thank you for drawing those sort of things out for us. And thanks again for
allowing us to come and visit the centre in Brisbane, when we were up there a few
months back.

40 MS EDWARDS: Pleasure. No. Sorry. I don't think – there was one thing I just
wanted to say then. Yes. Just in terms of those non-clinical spaces and services and
community-led space, I think they also have absolutely the strong preventative role
but also an intervention role because if you build confidence within community that
they can actually lean into these conversations and really reach in and recognise
45 when someone might even be potentially at risk, there's enormous both prevention
and intervention skills. And if they had confidence to hold space for people, that
goes a long way.

MR BUTTON: Thanks very much. Really appreciate your time, and certainly look forward to, I guess, continuing connections and really appreciate your submission and the work that you guys are doing. So thanks for appearing today, and I look forward to seeing you again.

5

MS EDWARDS: Thank you. Thanks for the time. Thanks for the opportunity.

MR BUTTON: Now, our next participants that are appearing will be Sidney Allo and Janet Timbert –. Sidney, how are you going?

10

DR ALLO: Thank you for your time. I know it's a back-to-back shuttle, but what I've got here is pretty much important. I would like to share – I was hoping I could share a slide, but I don't think I have that – bear with me a moment, please.

15

MR BUTTON: I think we can

DR ALLO: That would be stretching, but I suppose I would be able to send that to yourselves later. The key thing - - -

20

MR BUTTON: Sidney. Sidney, before we kick off, can I get you to - - -

DR ALLO: Yes.

25

MR BUTTON: - - - introduce yourself and tell us where you're from, purely for the transcript, so at least we know who's - - -

DR ALLO: Okay.

30

MR BUTTON: - - - appearing today as well?

DR ALLO: My name - - -

MR BUTTON: I mean, I've said your name, but if you introduce yourself.

5 DR ALLO: My name is Dr Sidney Allo. I am a professional economist, and I'm in Parkes of New South Wales, and I have with me Janet Timbert, who is – she will introduce herself

10 MS TIMBERT: Hello, everyone. So how do you do? I'm from Sydney, and I'm working with Dr Allo, here, and I know that one of his passions and mine, because I've done a little bit of work in supporting mental health, you know, and homelessness and what have you through the Uniting Church in Sydney – I'm not of that religion. I'm Jewish, myself, but I do believe that this church does a lot of good in the city, helping people off the streets and feeding them, etcetera, and I think it's a
15 massive problem, and I'm from Sydney. So I'm here in Parkes to work with Dr Allo, and his – one of his passions is this incredible rise of mental health problems in central west New South Wales, which encompasses Parkes and a whole, you know, series of towns, villages, outlying stations, etcetera, in this area.

20 Parkes is a massive, massive region, and we see every day and we hear every day of the terrible problems that exist here. I don't – I'm not of a background. I don't have any clinical experience or I don't have any – you know, a doctorate or anything, but I am – I've been a teacher for many years, worked in adult education for many years, have my degrees in that area. So that's my background and as well as other things.
25 But I do feel that there's a massive problem here in the central west, which Dr Allo will address, and I think that one of the things that I find by being here was that the country - I'll call it the bush. The country, whatever you say. The regions outside Sydney are largely overlooked in mental health funding, and that's why we have so many problems here.

30 I'm putting it down to its lowest denominator because, you know, I want you to know what happens here in the streets of Parkes, what we see around us and the things that the police face every day with mental health breakdowns and what have you. There are drugs rampant in the streets. There's all sorts of things happening. I
35 think a country town like Parkes, which prides itself in being unique and being a really historical place, doesn't see itself in that manner, but we see it as ordinary people living and working here, and I think all these things Dr Allo will address, yes.

40 DR JACKSON: Thank you.

MR BUTTON: Thank you. Now - - -

MS TIMBERT: And other things. Economic-wise, yes.

MR BUTTON: Really appreciate you both appearing today. Sidney, you can control the slides now, so if you want to present, you can do that. We've given you permission.

5 DR S. ALLO: One moment. Can you see my screen?

MR BUTTON: Yes, thank you.

10 DR ALLO: One moment. Parkes is Australia's mental health ground zero. 86 non-Indigenous suicides in 14 months. That's four times the national rate. \$2.3 million funding delivered, zero measurable outcomes due to national mental health agreement, which is - it's pretty much a flawed design, I would say. We demand immediate declaration of a rural mental health state of emergency with ring fence funding and consequences for failure.

15 I would say there's a catastrophic system failure in Parkes. 86 suicides in the last 14 months. That's equivalent to one death every six days here in Parkes. The economic loss is \$156 million per year. The ABS says each suicide costs 1.8 million in lost productivity. Healthcare, policing, service gaps, zero inpatient beds psychiatric
20 unit is 200 kilometres away, which is Orange. One psychologist per 15,000 people - that's the population of Parkes - against the one to 1200 in Sydney. We call it a tale of two Australias: the rural reality and the metropolitan standard.

25 What's the national Mental Health Association's role? No benefit realisation from past funding due to low KPIs for rural service priority, no penalties, failing to spend 80 per cent of funds locally. There's flawed metrics. The national no real-time suicide surveillance data logs 12 months, real outcomes from the reporting, wait lists, post-treatment tracking. We propose an amended clause 12 which is mandating
30 monthly reporting on suicide times, work frustrations, penalise underreporting by 10 per cent funding I'll give you a few examples. I've come across - can you hear me?

MR BUTTON: Yes.

35 DR JACKSON: Yes.

DR ALLO: Okay. I've come across a few - I'm an advocate for mental health, and I've done it for the last 15, 20 years. I was born in Sydney. I - but I did not grow up in Sydney. I lived in London advocate quite considerably against suicide and
40 mental health and I find that in Parkes, there are a number of challenges with mental health sufferers, and they complain that they don't get positive outcomes.

So sometimes you have the NDIS funding - there was for one of the sufferers and they had to get someone from Sydney to come to Parkes to do that for \$5000. There
45 was not much happening. And then with suicides, I remember speaking to - I'm part of a group called Mr Perfect, which works at helping men to not want to commit suicide, and I remember this particular day about two months ago, another gentleman

who said he was going to because he didn't feel comfortable, so he wasn't wanting to voice out his concerns.

5 There's a lot of farmers, kids, 17-year-olds, farmers who are committing suicide, and the number in the last 14 months is beyond the national average. It's 86, and that's a catastrophic event happening, and nothing is being done about it. Every six days, another Parkes resident dies by suicide while waiting for non-existent services. I find that the benchmark is normally based on Indigenous cultures to say the suicide rates are high, but this is actually non-Indigenous Australians who are - it's a
10 ridiculously high number, and something needs to be done and needs to be done fast. The baselines that are being used are basically outdated, and that needs to be changed.

15 Rural New South Wales receives \$120 mental health funding per capita against the city's \$220. Parkes receives zero from National Mental Health Association 2024 suicide prevention round. We're requesting rural mental health equity fund, \$50 million per year with 50 per cent allocation for high-risk LGAs - Parkes, Dubbo - 20 per cent to Indigenous-led programs, bonded rural mental health workforce, 500 new clinicians by 2026 with \$25,000 retention bonuses.

20 Five-point action plan, which I would say is emergency responses deployed 24/7 mobile crisis teams to Parkes, Dubbo mental health nurse, with audits by the National Mental Health Association. Data transparency: implement real-time suicide dashboards with public rankings overseen by the Productivity Commission.
25 Funding equity: legislate minimum \$200 per capita for rural mental health through Federal Treasury. Workforce: establish telehealth hubs in Parkes, tracking clinician numbers and distribution. Cultural safety: mandate Indigenous trauma training for all providers.

30 The funding reality is Parkes is lagging behind, and the economic loss is immense. Our call to action is to adopt a five-point plan, rewrite immediate amendments to clauses 8(b) and 12 with ring fence rural funding, join the Parkes summit in October, meet with survivors, clinicians to witness the crisis first-hand, publish funding by
35 postcode. Transparency is non-negotiable. Sunlight is the best disinfectant. Thank you.

MR BUTTON: Thanks, Sidney.

40 MR BUTTON: Before we get into – before we do get into questions, Sidney - - -

DR ALLO: Yes. Yes.

45 MR BUTTON: First thing, can we have a copy of the slides? Can you send those - - -

DR ALLO: Yes.

50 MR BUTTON: - - - to us?

DR ALLO: I would be glad to send that to yourselves.

MR BUTTON: And the thing that we do need to ask permission for is to then
publish the slides. Because it's a public hearing, whether or not we can actually
5 also - - -

DR ALLO: Yes.

MR BUTTON: - - - put the slides as part of the public hearing as an attachment so
10 other people can see them as well; is that okay?

DR ALLO: Yes. 100 per cent. What I would also like to mention – I've had a few
people who've said to me, "Why don't you focus on yourself? That's more
important." And I say this simply: when you're born, you don't bring yourself to
15 the world. When you die, you will not bury yourself. It's all about community. It
doesn't matter how amazing your product or your services. If you don't have
community, it's pointless. We have to reach one to teach one to look after each
other. The suicide rate in Australia is phenomenally ridiculous and it has to be
addressed, especially in rural Australia, which is the I've always only ever been a
20 city person.

I've lived in London, Barcelona, in Lagos, in Sydney, and coming to rural – I used to
– I was principal economist for Work Cover earlier on, and the stats are horrifying.
What I have seen first-hand – I've gone with a patient who – the system will not
25 really respond and just put him on the loop cycle because the doctors or whoever –
the practitioners would get an assured cash fuel, and he would say, "I don't get
positive outcomes." I remember going with him to a clinic once, and they restricted
his licence, and he would ask, "What have I done wrong?" And they would simply
say, "Well, it's not relevant. Don't ask us."

30

And I had to introduce myself formally, and then the doctor said, “Yes. I actually did that.” And I think it’s very unfair because a number of people have different challenges, but to make them feel like they’re completely stupid is beyond ridiculous, you know. We have enough data to use to back up what we’re saying,
5 and that – the suicide rates – I remember – I worked for a council for New South Wales. I was in a lift one day. There was a gentleman who and he said, “What for?” Now, his salary went from \$200,000 to \$400,000. It was not – it’s not always about money. You know, there’s that thing about comfort and pride “Man up, mate. Be strong.”
10
And so a lot of men – I’m not saying it doesn’t happen to women, but a lot of men find it difficult to come out and speak and say, “These are the challenges I face.” Do you wait until it then comes close to hand. I have friends who have committed suicide. It tears me to pieces, and it’s not acceptable for it to continue. There’s not
15 enough funding, not enough resources, no benchmarks, no tangible metrics to say this is what we’re going you create dashboards that will capture real-time what’s going on. With a farmer, there have been droughts, and a few people have not recovered, that’s not to talk about COVID in itself, which had had its own impact.
20
And there’s a long-term effect on people. There’s a gentleman who crashed his car to kill himself a few months ago, and if there was to say, “Listen, we see you have completely run out of money. We will create a fund where we will do the financial control. You focus on the business, but you become digitised. We will see exactly what you’re doing” transformation is also important. We keep talking,
25 talking, talking. It’s about time we started doing and not just talking. So it’s good to talk. We do talking in the city. We’ve got to talk in rural, that’s where the food comes from, and it has got to be done. It’s not good enough that it’s lagging behind considerably in cost and in value. Thank you.
30
MR BUTTON: Thanks, Sidney. Two questions for me.

DR JACKSON: Yes.

MR BUTTON: One is about – you’ve talked about this funding inequity, and so
35 describe how you’ve come up with a metric in terms of the model, where you’re saying there should be the focus – the focus was around ringfencing a component of the funding that goes into the national mental health and suicide prevention agreement for rural areas. Can you describe what that looks like? And I guess - - -
40
DR ALLO: Well - - -

MR BUTTON: The second part is, you talked about transparency of funding, which is something - - -
45
DR ALLO: Yes.

MR BUTTON: - - - that, certainly, we've mentioned in the interim report, that there needs to be greater transparency across the board, but you're focusing in on the funding transparency. So if you can comment on those two pieces for me.

5 DR ALLO: I would love to be able to comment, but I don't control the budget. So it depends on what your budget is, what the allocation is, what you ringfence and what you choose to release based on timelines, that will determine – so whatever I may be talking about may just be a miniscule amount of what the actual budget is. So it depends on what you choose to roll out or declare at any point in time. What
10 we're saying is what's important – this has to change. The dynamic has to change. There has to be funding to rural Australia. I've had stupid statements – excuse my Japanese. I've had stupid statements in terms of, "Hang on. Your colour's different." Is that what's important?

15 A few months back – some time last year, they closed a seniors' home, and I challenged it because it wasn't the right thing to do. You look after your seniors. Parkes is mainly a seniors community. You don't look after your seniors, and you're going to get old one day, and the same is going to happen, and what are we doing, what culture are we breeding to basically not give a damn about our seniors, then
20 where are we going? Is it all about money? There's many, many, many, many challenges facing Australia at the moment, and we don't need to add wellbeing to it. You've got to balance wellbeing; otherwise, you have no productivity to measure.

MR BUTTON: And the transparency bit – because you focused in on - - -
25 DR ALLO: Yes.

MR BUTTON: - - - the mental health funding in PHNs.

30 DR ALLO: Yes.

MR BUTTON: What we're saying is there needs to be greater transparency. We didn't necessarily go down to that minutiae.
- - -
35

DR ALLO: Yes.

40 MR BUTTON: But going to that minutiae, what would be the benefit? What's the benefit for local communities of having that minutiae in knowing their money is being spent?

DR ALLO: The – thank you for that. The transparency is – this is the funding
45 that's available. This is how it has been disbursed. This is the benefits realisation of what has been done. Working with Transport for New South Wales, I did some

evaluation and assurance, and I do financial models , and some people would bring – some department would bring projects to say, “It’s going to cost us \$5 billion. It sounds fantastic.” And then you look at the miniscule detail, you look at your underlying assumptions and variables, and if it doesn’t make sense, “Sorry, mate.

5 Take it back to the drawing board.”

It has got to add value to the people. It’s all about the people. It doesn’t matter what you do. If it’s not adding value to the bottom line, which is the people, then what are you spending on? That’s wastage. You’ve got to be able to benchmark what you’re doing, and you have to be transparent in saying, “This is what we’re putting the funding for.” But we’ve got to actually measure, not just throw the money at a cause or at a challenge and say, “Well, that should fix it. We’re giving you the money.” No. Accountability and ownership is also important. Now, if rural Australia has failed, then, of course, it has a knock-on effect on the Productivity Commission and the government at large.

And we’re saying it can be done differently. It should be done differently. It will be done differently. We’re in very, very, very unusual times, and the wellbeing is the most important. We have a mine here in Parkes and so, of course, they make a lot of money for the government responsibility is pretty much – I see a lot of stuff that’s – it’s gone underfunded for what’s going on the community. There’s not much money coming in. I sat in on some of the sports council’s meetings, and I was appalled they are happy to be asking for \$500 grants to \$1000 grants. The government needs to spend more money on sports.

25 You need to invest in sports tangibly because, that way, you’re going to stop children from carrying on – going into drugs and different things. There is nothing – there is a high drugs problem. There is a huge mental health problem. There is a huge problem. It’s not being looked at. It’s just being glossed over, and I look good on the camera. I look good in the papers. No, it’s not about that. It’s rolling up the sleeves, getting down to the things that are important, and it has got to be looked at. In transparency, there’s no other way around it. It has got to be clear. This is – these are the cards on the table, this is what we’re looking to achieve, working collectively. It’s not about blaming – a blame game. There’s no point in doing that. It’s damage limitation. This is where we’re at. That’s the reality. How do we move forward from here? How do we make it an inclusive society that adds value to the betterment of the nation? If we want to really drive productivity, you’ve got to look after the people.

40 DR JACKSON: Look, thank you so much, Sidney, for the presentation and for highlighting these issues. I think, going to Selwyn’s point, there is a lot of the sort of systemwide issues which, as you said, we kind of wrap in bureaucrat-ese, that you’ve provided the real life examples of what is happening on the ground, and some, you know, potential ideas there for us to really think and ponder about in terms of, you know, how our policy solutions might actually come through onto the ground and make a difference to the mental health services that are being delivered across Australia. You mentioned Mr Perfect just briefly as you were going through, and

we're also keen just to hear more about what is working on the ground, and what types of services, and are you able to elaborate a bit more about that, about the work about maybe the funding for that, and where that comes from.

5 DR ALLO: It's by one of the – I think it's a New South Wales member of
Parliament, Phil Donato. He funds it. So it's kind of like the first Sunday of the
month, we have a mens' walk. The second Sunday is a barbecue. Now, that has
been going on now – and I just remember very vividly this particular guy I saw, and
they said, 'Sidney, Sidney ...' – if you want to stereotype, stereotypes don't always
10 work. With this particular dude, you would never ever imagine that he would be
thinking that way, and he says, "I come to Safe Haven two, three times a week", and
I said, "What, you come to Mr Perfect?", and he says, "Well, I don't feel comfortable
to say what's going on with me", and that's the reality with a lot of people who just
hold it in and they don't talk.

15 Women are more open to sharing and discussing what's going on internally. They
don't necessarily internalise. There's very few – I'm not saying women generally
don't internalise, but a lot of men, "Come on, you're a man. Man up. Stand strong.
You've got to carry everybody along. What are you doing? Stop being a wuss",
20 right? And it has its knock-on effect. I think we need to change the narrative.
You're still a man. It doesn't stop you from being a man regardless, but there is a
different way. We have to explore a different way to address some of those
challenges for long-term prosperity. Prosperity is key in what we're doing.

25 Is prosperity all about money? No. I think we've put too much on that. Some
churches are doing something. I try not to go into the faith side of things, because it
opens a totally different perspective, you know, but with the organisation that I work
with and I'm part of, we try and plug in where it's possible, but there's only so much
because of limited resources available, you know?

30 MS TIMBERT: Can I say something, please?

DR JACKSON: Yes, of course.

35 MS TIMBERT: Please. Thank you. Look, I'm no expert, but I see what's around
me. I'm from Sydney, and now in the country. I can make comparisons. Here's the
problem. Everyone knows that NSW stands for Newcastle, Sydney and
Wollongong. That's where funding is mostly directed in NSW. This is largely said
around this area. P should be in that NSW, P, Parkes here. We're country. Country
40 folk are large – the country regions are largely overlooked. Why? They're remote,
quite remote from the bustle and hustle of Sydney. The medical services that are
needed to face mental health challenges are very low, and very unimpactful here.
We have a very small hospital here to serve 15,000 people, plus all our – this is in
Parkes town itself.

45 So we have Trundle, we have Peak Hill, Forbes – Forbes is their own council. They
have a little hospital. And so the crisis transport is to Orange, two and a half hours

- away. Now, you're probably aware of that. Parkes needs direct extra – really big funding to enlarge this hospital. If you want to go there for mental health services, I doubt there would be much available. Today there is a mental health expo down in Cook Park, and how long is this expo? For one hour. That's the emphasis they place
- 5 on this expo, and all the little organisations will be there giving out bags and pens and, you know, come to us, da, da, da. There has to be a focus on all these organisations getting together, and being almost one organisation that deals with mental health in this area.
- 10 It's a massive problem that there's so few medical resources. If you're sick, you have to travel in an ambulance for two and a half hours to get to a larger Orange-Base Hospital. If you're really sick, that's disastrous because Parkes can only handle 18, 20 bed – 22 beds. When I was there recently with a friend who was very ill, every single bed was full and a waiting list to get into the hospital. People find it
- 15 very difficult to travel, so here's the thing. Parkes – every town centre like Parkes – and this is a major, major town. Think of the Elvis Festival. It brings in 30,000 people once a year, and the other festival to Trundle, and what if people get sick?
- It's a nightmare. There are two ambulances. There's not enough mental health staff, nurses, doctors. There's two doctors in the hospital. It's a terrible problem that the
- 20 local politicians, council, I'm not sure what they're doing. Phil Donato, who Dr Allo mentioned before, is a brilliant representative of this area, but he's an independent. He can't do much, can he? He has got no party to back him, and if he goes cap in hand to find more resources, well, what are they going to do? You vote for – you
- 25 vote our way, you know, your hopes will be considered. Your thoughts will be considered. That's how I see it. In Sydney, there's a hospital every suburb, and mental health facilities, and a mental health hospital. Where's our nearest mental health actual hospital? It was closed down, was it?
- 30 DR ALLO: Yes, it was closed down.
- MS TIMBERT: It was closed down.
- DR ALLO: There's nothing in Parkes.
- 35 MS TIMBERT: And there's nothing in Parkes for anyone to be admitted to, other than the general hospital, put in with the general patients. It's a really sad state of affairs, and I think if this commission is going to shine and do its job, I think one of the big focuses should be on regional areas. Regional areas are really crying out. I
- 40 just compare the health services here to transport services, a bus everyone one hour. That's why nobody takes the bus, because they can't rely on public transport. Then there's a three-hour break every so often to get the kids to school, and then in the afternoon another three-hour break to bring the kids home, and the buses resume again for another two hours. That's transport services, and that's mental health
- 45 services – health services, and I think that's a – there's a big lack of that here.

If people knew that they had supporting health services, it would be something that the community would – you know, would realise the government’s doing something. I mean, mental health has been on radar for so many years, that’s all we “Not doing enough, not doing enough, not enough funding”. Go to Sydney and have a
5 look at every corner in the city, there’s someone homeless in the street. Every corner. And where do they go to? Who knows, you know? It’s such a big problem, and it has only happened because I think so many cracks have appeared in the health program, that people are falling through these cracks.

10 So they just sort of, you know – they’re largely carpeted over. Nobody wants to really know, and the money that should be – you know, we give so much money to sport, which I agree with, but some of that money – these sports clubs are very rich, very powerful, very everything. Some of that money – and the government gives. Look what they did. They built a whole new stadium in the eastern suburbs where I
15 lived, which was perfectly functioning, well – yet, they gave them \$2 billion to redo that stadium, or some \$1.5 billion, I think..... That money could have been much better spent on health services elsewhere. That’s how I feel, which has no equity at all.

20 DR JACKSON: Yes. Thank you so much.

MR BUTTON: Janet and Sidney, really appreciate your time, and really appreciate you spotlighting - - -

25 MS TIMBERT: Thank you.

MR BUTTON: - - - issues that are happening in rural areas in relation to mental health and suicide prevention services. Thank you very much for giving us a presentation as well, Sidney. We do appreciate that and, as you said, it is something
30 that we will then share as part of the transcript as an outcome from the public hearings themselves.

DR ALLO: Yes, please

35 MR BUTTON: It is something that we’re there to make sure that we’re taking seriously, and it is something that we will make sure is included in our deliberations about how do we make – how do we – what’s the consciousness that we need to ensure that it’s built into new agreements to focus on rural remote health services, and certainly in places like Parkes. So appreciate you appearing today, and hope you
40 have a lovely day, and hopefully we will be able to try and, I guess, look at providing some support and advice back to you guys in the future as well.

DR ALLO: Okay. I - want to thank you very much to you both. I want to presume that the outcome would be furnished publicly, or to everyone who has
45 participated in this?

MR BUTTON: Yes.

DR ALLO: So we will be able to see the outcome of the deliberations.
50

MR BUTTON: Yes.

DR JACKSON: That's right.

5 MR BUTTON: Yes, no, so all of the - - -

DR JACKSON: Yes.

10 MR BUTTON: - - - stuff that comes from today will be available on our website, so public hearings and certainly the transcript of the public hearings will be available for everyone post today, and will be on our - - - Posted on our website for people to get access to as well.

DR ALLO: Okay.

15

MS TIMBERT: Thank you.

DR ALLO: I also want to believe that it's not just about forcing a but in terms of the five-point action plans will be implemented.

20

MR BUTTON: Yes, no, certainly it is something that – as I said, it's something that we will consider as part of the overall mix, and to work out, well, what does it look like in terms of influencing, at a macro level, the work that we're doing as part of the national agreement in review as well.

25

DR JACKSON: Yes, yes.

DR ALLO: Okay

30 DR JACKSON: And look, just – I think just to be clear and transparent, our review is very much looking at the agreement. So the five-point action plan may not form part of what we put forward, because it's not within our terms of reference, but certainly in terms of thinking through these rural disparities, and how the next agreement deals with those in a more proactive way, I think something that's really –
35 you've definitely put this firmly on our radar, and it will be something that we think about over the next couple of months as we finalise. So thank you.

DR ALLO: Thank you very much.

DR JACKSON: Thank you.

5 MS TIMBERT: Thank you very much.

MR BUTTON: Now we will have a short break.

10 DR JACKSON: Back at 11.30.

MR BUTTON: Back at 11.30.

15 DR JACKSON: Thank you very much

ADJOURNED [11.07 am]

20 **RESUMED** [11.30 am]

MR BUTTON: Thanks, everyone, and welcome back. We will now resume our public hearings for the Productivity Commission Review of the National Mental
25 Health and Suicide Prevention Agreement. As mentioned earlier, for those who weren't present, at the conclusion of today's scheduled participants, I'll ask if anyone would like to briefly appear at this hearing, so we will make sure that those who haven't had the opportunity do get an opportunity, but if you could provide your email address in the Q&A or use the Q&A function to send a message to the team if
30 you would like to appear or present at the end of the hearing.

We also have a counsellor, Natasha Belmont, from Relationships Australia Victoria with us today for anyone who would like to chat or need some additional support. If
35 you would like to speak to Natasha, please email the address in the Q&A or use the Q&A function to send a message to the team.

We now have the team from Monash University appearing, so I would like to call - we have four people. We have Helen, Cathy, Melissa and Ingrid. And I thank you

for your submission and thanks for appearing today. I will ask - I know that each of you are doing a bit of a timed introduction, so I will ask who's going first and then we can throw to that person to kick off.

- 5 DR JACKSON: I think it can just take a little bit of time, sorry, for the IT, for everyone to come in with their cameras and come off mute. There we go.

PROF HELEN SKOUTERIS: Okay. Can you hear me?

- 10 MR BUTTON: and before you start, what I will ask each one of you to do is when you commence, if you could state your name and your title and the organisation you're from for the transcript, and then we can get into your opening statements.

- 15 PROF SKOUTERIS: Thank you.

MR BUTTON: So over to you.

- 20 PROF SKOUTERIS: Thank you very much. Thank you for your time today. I'm Professor Helen Skouteris from the School of Public Health and Preventative Medicine at Monash University. And would you like me to commence with my two minutes, or would you like to have everyone introduce themselves at this point?

- 25 MR BUTTON: If we start with yours, and then - - -

PROF SKOUTERIS: Okay. Great. Thank you. Yes. Thank you very much.

- 30 MR BUTTON: as you know the group, if you throw to the next person who's in the sequence..... and then they can do their bit.

- 35 PROF SKOUTERIS: I will definitely do that. Thank you very much. So we know targeted reform is urgently needed to address the unique mental health needs of groups often overlooked in national strategies. Here, I focus on young people experiencing moderate to severe mental illness, including those living in out-of-home care.

- 40 Psychological distress amongst youth aged 15 to 19 increased from 19 per cent in 2012 to 25 per cent in 2019, and suicide is the leading cause of death among 15 to 24 year olds. Estimates indicate that the worldwide pooled prevalence of any mental disorder diagnosis among young people is 10 to 20 per cent.

Despite this prevalence rate, key gaps remain in the design and delivery of youth mental health services, including (1) provision and evaluation of community-based

psychosocial support, (2) a lack of trauma-informed approaches and (3) the insufficient involvement of young people in codesign, delivery and the evaluation processes.

- 5 Approximately 46,000 young people are living in out-of-home care, and by that, I mean they are young people who are unable to live with their biological parents in response to the presence of maltreatment or neglect. Compared to young people not living in care, young people living in out-of-home care are more likely to be living with overweight and obesity and experience greater rates of homelessness, alcohol and drug addiction, school attrition and prostitution, teenage pregnancy because of their neglect, abuse, trauma and severe mental illness.

- 15 The Health and Social Care Unit at Monash, which I lead, is pioneering innovations to tackle young mental - youth mental illness with community-based trauma-informed approaches that have been designed with, for and by young people, including the healthy eating, active living matters, healing matters, and Australia's first peer-led youth psychological and peer support mental health service. Thank you for listening, and I'll hand over to my colleague Professor Cathy Mihalopoulos.

- 20 PROF C. MIHALOPOULOS: Thank you. Hi. I'm Professor Cathy Mihalopoulos, and I too am from the School of Public Health and Preventative Medicine at Monash University, and I'm a health economist, so a slightly different lens. So I'll start, and I'll talk about three main issues that we discussed in our submission.

- 25 So first of all, data infrastructure and evaluation gap. There's a critical lack of consistent outcome-focused data and minimal sharing across-services and jurisdictions. So we as Monash University advocate for real-time digital outcome monitoring and analytics, including possibly AI-driven analytics - although that needs to be properly assessed - to improve transparency, accountability and service quality. We advocate for more continuous cycles of evaluation so that it is ensured that services and the system as a whole are achieving what is expected. One-off evaluations are insufficient to ensure that our services and our system are continuing to achieve what we expect them to achieve.

- 35 We also advocate for greater use of economic evaluation to more broadly inform all investments in mental health services. Currently, economic evaluation is used in health technology assessment processes such as the Pharmaceutical Benefits Advisory Committee or the Medical Services Advisory Committee, but are limited or inconsistent in use beyond that. If considering the mental health system as a whole, this actually creates incentives for inefficiencies. Effectiveness and cost-effectiveness should ideally be routinely measured across all services regardless of who pays for them.

- 45 Now, the role of universities in reform. Universities, such as Monash, are underutilised. We believe they're underutilised in system reform despite their capacity for research, evaluation and workforce development. For example, Monash's Turner Institute, my group, the Health Economics Group within the School

of Public Health and Preventative Medicine, Helen's group and others, such as Turning Point, within our faculty demonstrate how academic institutions can lead in linking data, evaluating outcomes and costs and shaping policy.

- 5 It is welcome that evaluators are being engaged earlier in the development and provision of new services, an example being the National Early Intervention Service, where the evaluation process, led by us here at Monash, is central from the beginning and means that issues such as outcomes and monitoring are informing the delivery and the rollout of the service from the outset. This is a better process than bringing
10 in evaluators at the end when it's often too late to include the data that you need to include to do robust evaluations.

- And lastly, outcome measures and lived experience. Very importantly, currently routinely collected outcome measures are largely outdated, inconsistent across
15 services and largely disconnected from our current lived experience. Monash supports developing smart recovery-orientated metrics that reflect personal goals like hope, identity, social inclusion and economic participation and proposes partnerships with organisations such as the AIHW to design national frameworks and embed these outcomes in our linked national and state territory datasets. That's it from me,
20 and I'd like to hand over to Melissa now.

- PROF M. PETRAKIS: Thank you, Cathy. My name is Melissa Petrakis. I'm an associate professor in the Department of Social Work at Monash University and I'm the director of the Social Work Innovation, Transformation and Collaboration in
25 Health, or SWITCH, Research Group within our department. My PhD research 20 years ago was in suicide prevention at the emergency department community interface managing our national suicide prevention strategy, Living is for Everyone, LIFE, proof of concept project, so this discussion today is very dear to my heart and my research.

- 30 I found that a crisis response followed up by the same clinician can support people to resolve the problem that precipitated the suicide attempt in four to eight weeks. Statistically significant improvements are realisable in suicidality, depression and psychosocial domains of work, finances, leisure, social life, living situation, personal
35 safety and health by three months for many people who attempt suicide. Programs that enable this are not currently available across the country.

- Social workers are a natural fit for this work as they are trained to work in a person-centred way at the interface between systems and to advocate for and locate practical
40 response to services and help. Monash University social work is recognised as the leading Australian research institution in the social work field, according to The Australian 2025 Research magazine. The department also provides masters-level training for practice at an international level.

- 45 During and following the Royal Commission into Victoria's mental health system, I sat as chair of the board of Tandem, the peak body for family carers, and on various lived experience advisory committees, including working on the establishment of

regional governance in one of the regional areas in the north-west of the state. Respect for families is not genuine if not actioned and not actioned without representation and inclusion. Involving people with lived experience of an issue, their families and community members in the definition of problems and design of services prevents ill-fitting solutions and wasted resources and opportunities.

At Monash Faculty of Medicine, Nursing and Health Sciences, we've provided seed funding to interdisciplinary projects over the last two years in particular to find who across faculty has integrated consumer and carer lived experience into research and classroom teaching and curriculum review and redesign. We've ascertained where researchers and educators have interest but questions, challenges or need support to make changes.

Ingrid and I bring lived expertise, Ingrid with her lived experience and extensive expertise in this field, and I with my family carer expertise, and we're at the forefront of developing modules, resources and we're deeply engaged in establishing learnings worth taking scale nationally in the next two to five years. And now over to Ingrid.

PROF OZOLS: Thank you, Mel. My name is Ingrid Ozols. I'm an adjunct professor at the department of psychiatry, and I come with that lived experience, consumer and carer lens. I've got two points that I'd like to address, the first one about suicide prevention research. Since 2018, the suicide prevention research fund has been groundbreaking for suicide prevention research funding. Over 90 PhD, postdoctoral researchers and innovation grants. This initiative has also been an outstanding platform for lived experience coproduction in research methodologies, which were introduced at the very start of the fund's commencement.

Collaboration with lived experience throughout this initiative has taken traction and is a major influence of current, future research and translation practices. At a time when suicide rates are increasing, it is of grave concern that funding for the suicide prevention research in Australia ceased as of 1 July 2025. My second point is around lived experience leadership. Monash has been role modelling lived and living experience across governance, research, education and service delivery in mental health. Monash has taken a leadership role in appointing their first professor of lived experience to showcase its commitment to embedding consumer and carer expertise.

An example of successful lived experience collaboration has been the coproduction of an award-winning, evidence-based undergraduate Certificate of Mental Health within a small multidisciplinary team. 3000 frontline workers graduated. Again, as of January 2025, with a desperate need for a skilled workforce, lack of funding has discontinued this educational program. These issues require urgent attention. In partnership with the sector, Monash is well-placed to provide foundational support for these community needs. Thank you for this opportunity to share some insights for your consideration.

MR BUTTON: Thanks very much. Really appreciate your opening statements and your comments. We will move into asking some questions. Are there any other things that you wanted to highlight before we – Angela and I get into questions?

5 PROF SKOUTERIS: Not at this stage, no.

PROF MIHALOPOULOS: No, I think we're okay for questions.

10 MR BUTTON: Excellent. So let's start. First thing I want to go to is to get a bit more of an understanding, Helen. You talked about mental health support and focusing on trauma-informed support for kids in out of home care. What does that look like? And you talked about getting some decent outcomes. Can you tell us about some of the outcomes and what's being achieved in that space at the moment?

15 PROF SKOUTERIS: Yes, yes, yes.

MR BUTTON: And why I want to draw some inferences there is because we do know that many young people in out of home care – and you certainly would have seen this. Many young people that end up in out of home care end up getting caught
20 in the system and do end up in the youth justice system as a result, and then progress to incarceration, etcetera, as well. So if we're focusing on what is trauma-informed practice and what are mental health support services in those early stages, then what's the prevention process that might be able to occur over a longer period of time?.

25 PROF SKOUTERIS: Yes. Yes, no, thank you, and that's exactly what's happening and what we want to prevent for these young people, especially as they transition out of care. So it's not enough to support them while they're in care, but to also consider that we are literally booting them out at the age of 18. We are now extending to 21.
30 That has to be embedded firmly. That was a recommendation from the COVID-19 pandemic which is starting to happen around Australia, which is great, but they still, when they are, you know, I guess, transitioned into the real world – they don't necessarily have the life skills that are going to support them that are able to help them transition into a life without the constant supports that they've had, potentially,
35 through the child protection system.

And so what we have done in Victoria, and it has been scaled in South Australia as well and in some parts of New South Wales – we've created the Healthy Eating, Active Living Matters program, which was created with, for, and by young people to
40 build in those – what we now know are much more psychosocial supports because they're very – their lives are heavily medicalised in terms of their pathologies, and so they're constantly, you know, needing to see a GP or a psychiatrist, and as young people, that we know is not necessarily what they want, or they might need.

45 So in addition to that, how can we help them with just the normal routines of life? So healthy eating, physical activity, you know, being able to function with routines in a household. You know, being able to feel a sense of belonging and a sense of

value and trust when they're in a situation where they're being cared for by complete strangers, and they're living with complete strangers.

5 So how do we flip it on its head, flip the narrative, and build in those psychosocial supports which well-meaning and functioning families provide for their children? You know, the driving them to the local football club and watching them play sport. The, you know, growing of vegetables in the garden and helping them contribute to that and to the shopping and say, "What are we going to be cooking tonight?"

10 So one quick quote that I can give you from the power of HEALing Matters is a young boy who, you know, we interviewed, who loves HEALing Matters, and basically said to us, "I love HEALing Matters because it's helped me to understand that I should be walking the five kilometres to my dealer to pick up the drugs," that, you know, he's dependent on, "and not catch the bus". Now, we're not going to
15 solve that drug addiction overnight with HEALing Matters, but when it's embedded in the system, which it is now in Victoria and becomes best practice, everyone is focused on how we can holistically support those young people.

They start thinking differently because the program has been designed by them.
20 They can identify with it. You know, it's what has been identified. What we have also done is also bringing in the LGBTIQA+ supports, the mental health supports, the addiction supports, the smoking cessation supports, the Aboriginal and Torres Strait Islander cultural specificity, and so what we're finding is that HEALing Matters has moved beyond just, you know, the healthy eating and active living –
25 right – which is what it started, to this, as I said, much more holistic psychosocial support for young people, and it's definitely working.

MR BUTTON: Excellent.

30 PROF SKOUTERIS: We just need to keep funding it. You know, because that's the problem. Right? You know, governments commit to it, but then if there's no funding, it will all fall apart.

MR BUTTON: And that was going to be my next question, not necessarily about
35 the funding itself, but more about the evidence and any evaluations that you've done.

PROF SKOUTERIS: Yes. Yes.

MR BUTTON: You can provide those to us because As you appreciate, out of the
40 work that we've – one of the recommendations in the interim report was to focus on those who are missing out on the NDIS with the changes, in terms of eligibility requirements, and certainly - - -

PROF SKOUTERIS: Yes.

MR BUTTON: The 500,000 that are requiring psychosocial report..... at the moment, that there is a large proportion of those that are young people. So it would be good for us to be able to provide some evidence back to government to say, “If you’re thinking about doing things in this space, here are some proven methods or proven strategies.”

PROF SKOUTERIS: Yes. That’s right. Yes, and we definitely have all of that. Of course, you can’t do randomised control trials – we tried that – with young people because of their, you know – they churn in and out of residential care, and it’s a very volatile system from that perspective, and as you say, you know, they are also in and out of juvenile justice. So how do we create a system where we are collecting data in a way that also is respectful of them, because they are over-researched and they literally tell us to eff off when we want to do research with them. We have been very privileged to work very closely with lived experience organisations like CREATE and governments to be able to collect the data and publish it. So we do have those peer-reviewed publications, and they’re prolific now, which is great. We do have the evidence base, and I would be very honoured to share all of that with you.

MR BUTTON: Excellent. Thank you very much.

DR JACKSON: Cathy, I thought your ambition there around not only having outcomes – an agreed set of outcome measures that we actually regularly collect on, but then also linking the data across the board, was ambitious, perhaps, in terms of where we are right now. Can you maybe just give us a bit of an understanding of where you think – where this works well, like, are we seeing this data sharing occurring, and how it can then inform service delivery on the ground, and what are the barriers, if you like, from the – because it was, you know, an objective with the prior agreement? We haven’t seen – we’ve seen some progress, but perhaps not as much as we would like, and what the ongoing barriers are, and how do we overcome those with the new agreement.

PROF MIHALOPOULOS: Thank you. That’s a terrific question. So I think there’s movement in the right direction. So if we consider, for example, the national data hub via the AIHW and PLIDA, the person level integrated data asset, I think all of those initiatives that have been happening have been definitely going in the right direction. So we’re able now to link, you know, for example, through the national data hub, MBS data with hospital data and other datasets that are available there.

What is missing in some of those – so we can kind of get an idea of what services people are using. It's not perfect. Right. And I think NDIS is part of that too. So we can maybe get a picture of the kind of services that people are using, but not how they're travelling, in terms of outcomes, unless you kind of – I don't know – maybe
5 have some proxies in there, but they're not ideal either.

I do know – but then we've got missing bits of the puzzle, for example, where we've got the primary health care network minimum dataset that's not currently linked to that. Now, that's an important piece of mental health service delivery. And there's
10 lots of rich data in that dataset, and I know because I've used it in some of the evaluations that we've done, but it's not well-linked into other services. So we can understand, for example, what services people are using as part of the PHN system, but it's very, very difficult to know easily what they're using outside of that and so you can never get this full picture of exactly what services people are using and
15 outcomes.

So outcomes are – you know, it's a matter very close to my heart and it's one that I'm very interested in. So if we think about, you know, a lot of State-based services will have the K-10 being used in there as a measure of outcome. Now, it's not great.
20 A lot of people with lived experience and others will say it's probably not the best measure to use, but we kind of use it. And then we've got state-based services that use other outcome measures and then other services will use others. So they're all different, and so there's no nationally, kind of, I guess – not mandated, but agreed set of outcomes. And I don't think it's only one measure that will do the trick. Right.
25 So I don't think it's one measure. It could be, you know, three or four measures. So you might need something that focuses on symptoms.

Quality of life is really important. Recovery focus and quality of life measure is important as well. You know, services that people use is kind of an outcome too and
30 important for economic evaluation, but I think having that discussion of what it is that matters to people and having agreement across Commonwealth-funded and State-funded services across the board will take us some way towards, you know, this goal of having both linked data, outcomes measures, and it wouldn't be impossible to do. As I said, I think we're part way there, and we've got PLIDA and
35 the national data hub and other sorts of great initiatives. We've just got to go that little bit further.

MR BUTTON: I wanted to bring in Melissa and Ingrid here in relation to the workforce. And we've seen, in terms of the recommendations, the interim report.
40 We certainly would – we're suggesting that we do need to think about what is the scope of practice for the growing number of peer workers that are in the sector. Understanding some of the work that you're currently doing, in terms of supporting peer workers in undertaking training, etcetera, can you talk a little bit about that and certainly what would the benefit of going down the path of establishing a scope of
45 practice for peer workers in this space look like.

PROF PETRAKIS: Ingrid, are you happy if I start? Thank you so much. We've very excited by the establishment of national peaks for both consumers and carers, and there's a lot of potential for those peaks to contribute to workforce development as well. One of the things – I spend part of my week – as do many academics at
5 Monash, actually, I spend part of my week in clinical services as well as part of my week teaching and in research at the university itself, and one of the things that I found working at St Vincent's Mental Health Service and working with Monash Partners at Eastern Peninsula, and at Monash Health, of course, is that it's very difficult to sustain people in roles when they're lone workers, and the funding
10 essentially still means we have a lot of lone workers.

Even as a little, baby social worker, with a psychology degree and a social work degree behind me, being a lone worker in an inpatient setting as my first job was pretty intimidating, and when you're not the majority workforce, which is nursing, or
15 the leadership workforce, if you will, which is still medicine, despite a number of the most promising interventions, being psychosocial, what we have is a setting where, for people who have already had traumatised - or traumatising experiences and memories from inpatient stays, often against their will, and treatments that they would not choose and had very negative side-effects that continue to impact their
20 lives – these are not settings where it's safe to be by yourself.

So trauma-informed care means the whole of workforce and really the planning around redesign of our spaces and our workforce teams, taking responsibility for supporting one another. We've got risk-averse environments and we've got
25 environments that are very much about – the really important measures around how well we're doing and what we're doing that Cathy was just talking about are sometimes used in practice more as checklists and things we must do. They're not being used for how they were designed to improve patient care and make sure that we're doing the best patient care. And really the people who are struggling most are
30 lived experience workers who we churn through, not because they're not strong, capable workers, but because they're poorly inducted into a complex system. That's a biomedical system. Sorry, Ingrid. I said too much. Over to you.

PROF OZOLS: No, not at all, because that's a really nice segue to what my
35 suggestions were around this question. And thank you for the questions. This goes back, I think, to educating everybody, not just the lived experience peer workers, but also the clinicians and all the other team members that – we're working together as a team, so that we understand each other, and that's that co-production piece of working together and understanding, "Well, this is my area of expertise, and this is
40 my area of expertise," and then addressing those power imbalances.

So how do we actually share that power so that we can all feel more knowledgeable and confident and comfortable? And as Melissa said, that whole notion of
45 psychological safety is actually true for everybody in the workplace, and we all do play under those same legislative rules. It's how do we actually help dive into the specifics that the lived experience workforce needs so that the workplace is better educated and understands what that workforce requires to feel safe, to feel supported,

and then having those supports in place. So it's one thing to say – tick a box to say yes, we've got all those, but the essence is – is having those in place and being genuine, which then goes up, I think, into leadership and workplace, CEOs, executives, board members all being onside. So I think that goes back to them being
5 educated. And we saw that in our particular undergrad: that all the different cohorts that came to our programs, both clinical and non-clinical, found them invaluable in learning how do we work together in that collaborative coproduction methodology, so it's about us working together as a team to learn from each other and to enrich our learning, and to create new knowledge. So I'm very much of the education model,
10 and suggesting that we all come together to work together openly, honestly, and addressing power imbalances that occur within all of the different teams and the different levels; you know, lived experience has their own power imbalances just as much as there might be those between clinical and non-clinical groups and workforces. So I hope that helps in your considerations.

15 MR BUTTON: Okay, that's very helpful. Thank you. I know we're running out of time. I do want to ask one very quick question, and I'm going to ask, Cathy, for you to speak to it, because you did mention it, and if you can keep your answer very short, that would be great.

20 MR BUTTON: It's in– in relation to the AOD schedule that we've suggested, and the alcohol and other drugs schedule that was suggested, and you guys, in your submission, are saying you're a big supporter of having an AOD schedule. I'm going to ask the question: why?

25 PROF MIHALOPOULOS: Well, I think that – look, it's not entirely my area of expertise in terms of the submission, but I think it is a very important unmet need right now in terms you get a lot of comorbidity in people with mental health problems and drug and alcohol problems, so I think, you know, having better
30 integration and having that together and being formally considered is a really, really important part of holistic treatment for people that do suffer these very important comorbidities. I don't know if anyone else from the team wants to quickly chime in there with anything else.

35 DR JACKSON: I think, Helen, your comments previously did go to some of the benefits - - -

PROF MIHALOPOULOS: Yes, that's right.

40 DR JACKSON: - - - of an integrated approach.

PROF SKOUTERIS: Yes.

PROF MIHALOPOULOS: Correct. I just wanted to say that's exactly right.

5 PROF MIHALOPOULOS: These – you know, young people, in my case, are dealing with drug addictions, with, you know, suicidal thoughts, but also with, you know, prostitution, teenage – and there's so much going on for them, and we cannot – cannot – consider it in silos, it's not fair on them.

10 MR BUTTON: Okay.

PROF SKOUTERIS: Yes.

15 PROF MIHALOPOULOS: We have to consider the person as a whole, and I think - - -

PROF SKOUTERIS: As a whole.

20 PROF MIHALOPOULOS: - - - to kind of favour one bit over another - - -

PROF SKOUTERIS: No.

PROF MIHALOPOULOS: - - - is not - - -

25 PROF SKOUTERIS: It doesn't work.

PROF MIHALOPOULOS: - - - the best treatment approach for - - -

30 PROF SKOUTERIS: No.

PROF MIHALOPOULOS: - - - the people, so I think it's got to be considered, and the comorbidities are very large.

35 PROF SKOUTERIS: Yes.

PROF MIHALOPOULOS: Yes.

PROF SKOUTERIS: Yes.

40 MR BUTTON: Thank you very much.

PROF OZOLS: Just to add to that, that goes back to the education piece, that we all need a bit of education around trauma-informed care, around recovery, around

understanding AOD, around understanding all the different human conditions, as complex as they are, but having that general insight can help us to work together again.

5 MR BUTTON: I really appreciate that, and thank you very much for your time. Thank you for your participation and your interest, and certainly look forward to you guys, I guess, following as we go along through the process and - - -

PROF OZOLS: Yes.

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MR BUTTON: - - - looking at getting the final report out in October. So thanks very much for your time today.

PROF MIHALOPOULOS: Thank you very, very much.

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PROF SKOUTERIS: Thank you.

PROF MIHALOPOULOS: Brilliant. Bye bye.

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MR BUTTON: Our next participants will be from the National Rural Health Alliance. We've got Susi Tegen.

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MS TEGEN: Fantastic. Thank you very much. You might have to move your – yes. Thank you very much, there is two of us here. Margaret Deerain's an apology. We've got Gigi O'Sullivan and Susi Tegen. I'm the chief executive of the National Rural Health Alliance, and thank you for including the National Rural Health Alliance in the National Mental Health Agreement discussion. The care economy plays a really important role in the daily lives of people living in rural, regional and remote Australia, and it is crucial that they are considered, and considered separately. They currently make up 30 percent of the population, which is over 7.3 million people.

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The organisation that I represent has 55 member organisations, they're all peak bodies, and diverse membership includes representations along the patient journey, but also along the health professional journey, and that includes educators, researchers, and also those people that deliver care, and I would just like to say to put it in context, rural Australia, which only makes up 30 per cent of the population, is currently bringing in two-thirds of Australia's export income. It is also bringing in 90 per cent of the food Australians eat, and despite the fact that they're only 30 per cent of the population, they're bringing 50 per cent of the tourism income. They are productive. They are resilient, and they are kicking well and truly above their

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weight, and we really appreciate being involved in this Productivity Commission session for mental health, because rural health has been totally left out of productivity discussions, which is quite amazing considering we bring in so much of Australia's wealth.

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Mental health challenges in rural, remote and regional Australia are significantly impacted because of the droughts, the floods and the fires, and many communities are having to deal with floods one year, and, 18 months later, they're dealing with a drought, which, despite making such an amazing impact economically, it is taxing to the individuals, and the impacts on productivity are reduced workforce participation, absenteeism and presentism, decreased economic output despite the fact that they're still producing a considerable impact on farming, mining, fishing, forestry, tourism. Higher healthcare costs, although, currently, per person, they're actually receiving \$1000 less per person than somebody in the city, and, in addition to that, they are receiving less disability payments than people in the city. Altogether, that's about \$8.3 billion less in rural Australian than it is in urban Australia, and, in 2023, that was 6.55 billion and \$848 per person per year less, but now it's \$1000.

The other challenges for rural areas compared to the city is that there is a limited access to services due to geographic isolation, workforce shortages, lack of specialised care. In addition to that, it is because the policy and funding is not fit-for-purpose, and often that turns out to be less funding for communities. The social isolation, it is becoming more of a problem, because a lot of the businesses and properties are merging or are further and further away, and they're losing track of what it actually means to local people. Banks are closing, and banks have often been a place of gathering, which has assisted people to have that social contact and also support.

The stigma surrounding mental illness can be prevented, and often individuals are trying to seek assistance, but there is inadequate treatment or a lack of understanding of people that use telehealth from the city to say, "Why don't you go to your local gym; that will help you with your exercise," when they have no idea what it's actually like in those places, and then people stop utilising that service. I mentioned before the climate impact on mental health, you know, and policy that is almost, you know, not paternalistic or maternalistic, but shows a lack of understanding by using words such as "we will help you to be resilient". Don't forget this is in the context of making a major contribution to the economy.

In addition to that, workforce development and the support for workforce development in rural, remote and regional communities is just not there. Yes, there has been some funding for rural training; however, it still ends up, often, in cities, as does rural research funding and support, we must do more of that, including with Indigenous communities.

And just lastly, you know, if Australia were a company and 30 per cent of your company was producing so much of your income and the wellbeing for the rest of the company, you would think that there would be more flexible policy, more funding

and more support for those communities to do even more of what they're doing so well. We do have some recommendations, but thank you for including us, and we look forward to your questions.

5 MR BUTTON: Thanks very much, Susi. Appreciate it. Happy to go straight to the things that - in terms of recommendations or the things that you think might be able to make a difference, certainly in focusing on rural, remote areas through the National Mental Health Suicide Prevention Agreement. You mentioned funding and different funding models. Happy to start there, if you like, and certainly can then
10 walk through some other pieces.

MS TEGEN: Thank you. Well, the thing is we've been speaking about being population-health-needs-based and also being multidisciplinary for a very long time, but it isn't actually occurring on the ground as it should be, and part of that is the
15 inflexibility of the funding. And for example, I mean, let's look at disability. There are discussions at the moment about stopping reimbursement of travel for allied health professionals. Now, if they can't go and travel to those sites that the service is needed - and there is no public transport in many of these regions; there are no taxis or Ubers or anything else - you know, how do we ensure that the services get to
20 where they need to be so that mental health issues are actually nipped in the bud at the very beginning?

And so the National Rural Health Alliance has been working with communities around Australia, in particular MMM5 communities, because those communities in
25 particular - so they could be anything from, you know, hundreds of people to, let's say, five to seven thousand or 10,000 people, because they're often hubs. There is a massive underspend and a massive lack of service delivery in those communities across all of the professions. You know, dentistry, general practice, primary - any primary care service, mental health, psychologists.

30 And we hear regularly from those clinicians. Sometimes they ring us up crying and saying, "We cannot believe that more funding is going to those regions that actually can get on a bus and can go to another service. We can't even access the basics. You know, many of us can't even go away from our families, because we have a
35 family, we're a carer, you know, for our in-laws, and in addition to that, I'm expected to travel many kilometres and then the PATS scheme might pay me \$100 for accommodation when, actually, the accommodation around that centre costs about \$210. I don't have the money.'

40 So our solutions are about multidisciplinary funding based on a local population health need. Start with MMM5, because those are the communities. The gap goes like this, and we'll send you the graphs. This is PBS, MBS, NDIS, disability, hospital funding. It is massive. The discrepancy is outrageous. I'm ashamed to say that we treat these people as if they were third-world citizens. And so, you know,
45 we'll show you the graph.

We think that by having block or blended funding for those communities, you have flexible funding to be population-health-need-based and people can recruit the workforce or the way they need it delivered or a blended way of delivery that is actually sustainable, just like an Aboriginal health service, and it allows for also the hub and spoke model.

So I'll use Mareeba in Queensland as an example. That community was going to lose their multidisciplinary clinic. The community, which was made up of local government - these are all non-paid people - local industry, local tourism, local health workers, private and public, and they all got together and they raised money to do so.

Now, if I told somebody in Canberra in Deakin and if I told somebody in Fitzroy, "Hey, guess what. You're not going to have a service and you're going to have to drive up to Ballarat to get a service. There's no other service," I can tell you they'd be outraged, but this community raised money and they basically bought out the service and are now trying to deliver care in other communities, and they've got a mental health worker that they could employ, they've got an aged care person that they could employ, they've got a rural generalist that they could employ to go into another community called Dimbulah. But the local hospital outreach centre that's in Dimbulah with five empty spaces - nobody's using it, hasn't been used for five years - is not willing to give it to them to use. They've been asking for three and a half years.

And they also don't have flexible funding to employ those people, because Medicare does not cover the cost of service. So they've got the solutions, but they do not have the funding, and they do not have the flexibility in funding, and we know that they could deliver that service. And this is not only one community.

So we're saying under the National Rural - under the National Reform Agreement, we need a compact between the Federal and State Government to say, "We're willing to work together." It's fantastic that the Minister now looks after mental health, disability and health, because in rural Australia, they're all together anyway. It makes sense. They often service all three of those.

And under a national reform agreement, you have that compact to deliver the funding. And I mentioned before it was \$6.55 billion in 2023. It is now over \$8 billion. You know, if we underutilise that funding per capita, well, then we should make a national rural health fund, and under that is a mental health fund for rural Australia, which is set aside - it doesn't go back to the city. It's set aside and it can be utilised for those, you know, flexible funding models.

We're also saying that under that national rural health strategy and that block or blended funding, there should be some funding for infrastructure so that if there is a hub and spoke model or if we want to expand mental health students to train in those rural communities - at the moment, they're staying in people's houses, because there

is no accommodation when they're training in rural communities. And so we think there should be some infrastructure funding for housing and expansion of clinics.

5 We also believe there is an opportunity - because there are some really amazing stories of where people are solving problems, just like in Mareeba or Kimba or in Bogan Shire in New South Wales - where if we had an innovation hub, which is about rural health innovation, things that the Federal Government has funded, like IMOC grants or scholarships - it's all shared on one hub so people can learn from what is working well.

10 So for example, did you know that Latrobe Uni in Bendigo - just so that they can train the future psychologists in rural Australia, rather than them going to the city, they do all the paperwork for the clinician, that is usually a solo clinician, so that they can take a student. And they support them to take the student. And those sort of things need to be celebrated and need to be adopted or adapted in other training programs, but they're not, because there isn't a national rural innovation hub.

20 And we believe we need to share more about what the government is investing in but nobody seems to know about, and the National Rural Health Alliance has been very supportive and mentored a lot of communities, and we say, "Look, we know this community in this part of Australia is able to do this. You know, maybe you could learn from them." We're not actually paid to do it, but we do it because we don't want it to be wasted, and so they're some of the things that we believe are important. Rural needs to be separated. Rural needs to be funded because it isn't currently funded equitably. You wouldn't have the big underspend, and the productivity is in rural Australia. Let's just grow it.

30 MR BUTTON: Thanks, Susi. Couple of good questions. A lot to absorb in that. I want to come back to some of the rural health workforce models, and obviously what we do see in a more urbanised area is the growing numbers of peer support workers. Is that something to think more about in a rural area where there is limited access to GPs, limited access to psychologists, psychiatrists, etcetera? Is it something that we need more of a focus on, maybe using those people that are already there, as opposed to thinking about who else can come in? That it's building a peer workforce model to support rural communities, and with that, there's much more of a focus, then, on the preventative .end through a peer workforce model.

40 MS TEGEN: Yes. I mean, if you're looking at the underspend, which we know is occurring, and we've got a higher suicide rate in rural Australia, so the psychological stress is probably similar in urban and rural. It is probably happening more often in rural, and the suicide rate is higher, and often it is because there isn't a workforce that they can talk to that's independent and without stigma. And so that is why things like the men's shed and the, you know, over-the-fire discussion for the Indigenous groups and things like that have worked really well. And they're not run by psychologists, psychiatrists and rural generalists, and I think they've played a really important part.

There are also those clinicians that are not covered by Medicare, like the counsellors, and I think there's definitely an opportunity to bring them in because they're currently not covered by Medicare. And, for example, for farmers, the financial counsellors that are actually not trained in psychology often end up being a conduit or being a –
5 you know, being a carer, in a way, because there is nobody else, and because they're already in people's homes, which is really important.

Telehealth has often been seen as a way of dealing with the gap, but actually, it is not as useful as people think it is. It is valuable if it's an extension of the existing
10 services at a local level because you have more collaboration, people understand the context, and people know that there is a sharing of information so that they don't have to continuously tell the whole story again, and that is what's been happening with telehealth services from the city. You get a different person. You are disconnected. You – like, it's just – it's not working to the same level that, you
15 know, people might think we could do it. And I think if anything, it'll put people off.

I think if you can develop a different scaffolding of services per rural community, and again, start in MMM5 because that is where the biggest lack is, and if you can retrain individuals because there are people that might be doing one work, like a
20 nurse, but isn't interested in nursing any more but you might be able to do some retraining. I think there is an opportunity, and they want to stay in rural areas, and if you look at the Indigenous population, if they're in rural, they do not want to move away. You know, we can even tell with the figures of allied health professionals and generalists, rural generalists, if they are from rural communities, they're even more
25 likely, exponentially more likely than a white person to go back or stay, which is really interesting. So – and I think – so to answer your question, yes, there's an opportunity to expand the scope of others, as long as they are protected because often they're isolated, and they need the support on the ground, and what currently happens is the people on the ground, no matter which clinicians, they're not supported.

30 MR BUTTON: Okay.

DR JACKSON: So just – and just trying to pick up some of the threads, the local – the place-based approaches, from your experience, the role of PHNs working the
35 local – and I think you've just provided an example where it's not working very well, but where it is working well and whether you think that that sort of collaborative commissioning approach, what role it might have in implementing the next agreement.

40 MS TEGEN: Yes. Look, it's – it definitely depends on the CEO and the board of the organisation with the PHNs. We work with some excellent PHNs, but we also work with some that are making it more difficult for the communities, and it's really – it's a waste of money and it's terrible for those communities because they're not being paid to solve problems, you know. For Sandy Gillies up in Northern
45 Queensland – North-West Queensland, amazing. Outstanding person. Outstanding PHN, and very much grassroots, evidence-based.

You've also got the Murray PHN in Victoria. Matt Jones again, just, you know, he's got an attitude of plenty, very easy to work with. But we have seen some that just – it's almost as if they're going out of their way not to support the communities. It's – yes. It's not – and I think you should consider, for those communities where local
5 government has taken the reins or where communities have formed alliances and have formed entities, they should be able to – for example, with the, you know, Medicare bulk billing things, if there is no Medicare bulk billing clinic in those regions, and part of what they want to do is in mental health, and they can't get a Medicare bulk billing clinic going, then give it to the community because I can tell
10 you, they can get it going, and local government is working with them.

When I was speaking about Mareeba or Bogan Shire or Kimba, for example, there are some places in Tasmania as well, it is a collaboration of the coalition of the willing. And they include industry because, as I was quoting at the very beginning,
15 those figures, if you don't work with tourism and if you don't work with industry, you do not know what workforce needs you have, you don't know what the mental health needs are, you don't know what the capacity is, so Mareeba, for example, has 10,000 PALM workers. They've just got just as many grey nomads. That is not in the budget of federal and state government. Right? And so they're already on the
20 back foot. If you do not work with industry and local government, you are missing out on the reality of what the community faces.

MR BUTTON: And so potentially, Susi, I'm just going to – spitballing here, could you be thinking about something that focuses on specific regions where there is a
25 greater flexibility in the use of mental health funds, both through a PHN and through the local hospitals, to then look at some different approaches to doing things, is what you're talking about?

MS TEGEN: Yes, absolutely, and again, I talk about Mareeba. I mean, they had
30 run a mental health program, and they brought all of the stakeholders on board, and then there was a PHN tender. They put in for it, and it was given to an entity that was an hour and a half, two hours away, that had no connections with the ground, and I know that Mareeba is so well-connected. They meet with all of their clinicians regularly. We work with them. We mentor them. And they would be an excellent
35 organisation. They work with the Aboriginal health services, with the aged care sector. They would be so good at it.

But you know what they're doing? They're raising funding through fun runs. They're raising funds through a wheelbarrow race because nobody's willing to give
40 them the money so that they can deliver that care. Like, it's just – and there's so many good news stories like this, and they're hamstrung. So communities like these and, in particular, MMM5 would be excellent because that's where psychologists, GPs, allied health professionals, nurses are at their lowest, and often, ambulances are having to pick up the pieces because they're the only ones out there and many of
45 those people are volunteers as well.

DR JACKSON: Look, we have come to time, but is there anything else you would like to add before we stop? And I'm just going to say, the coalition of the willing, I may re-use that in future discussions.

5 MS TEGEN: Yes. Because I'm so proud of these communities because – and I say it in the most humblest of senses because, you know, they're so passionate, and you just wouldn't get that in the city. I've lived in both country and cities, and you know – and I just want to say, look, thank you so much for including us. Thank you for listening to the communities that we represent and the clinicians we represent, and I
10 have to apologise that I'm so passionate, and you're probably thinking, "Oh my god." You know, which is – but you know, I know we've got a short period of time, and that was the only way I could get it across. So thank you.

DR JACKSON: Thank you very much.
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MR BUTTON: Really appreciate you participating today and putting your case forward. It certainly has been heard well and is part of something that we do need to consider as – in our process as well. So thanks very much, Susi, for dialling today.

20 MS TEGEN: Thank you for your time. Bye, bye.

MR BUTTON: Now, our next participants are from the National Mental Health Consumer Alliance. We've got Priscilla Brice and Jen Nixon.

25 MS BRICE: Hi. So Jen is my colleague. We've prepared a statement, would you like us to start with that?

MR BUTTON: Yes. That would be great. And if you – at the beginning of your statement, if you also provide your name and your title and the organisation you're
30 from, for the transcript, that would be great.

MS BRICE: Perfect. So my name is Priscilla Brice, and I am the CEO of the National Mental Health Consumer Alliance. I'm joined here today by my colleague, Jennifer Nixon.
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MS NIXON: Good afternoon. My name is Jennifer Nixon. I am the national policy and research manager at the Alliance.

MS BRICE: The National Mental Health Consumer Alliance welcomes the Productivity Commission's interim report of the review of the national mental health and suicide prevention agreement. We thank you for the opportunity to appear at this hearing. The Mental Health Consumer Alliance is the national peak body for mental health consumers, and it is led entirely by mental health consumers. Established formally in July 2024, our identity is grounded in the powerful principle, "Nothing about us without us." We united for a federation of state and territory consumer peaks, which means that our voice is shaped from the ground up, not imposed from the top down.

We are led by an independent chairperson and guided by two independent First Nations board members. We are here to advocate for human rights, for person-led care and for reform that is led by consumers. We welcome the interim report by the Productivity Commission that agreed with our submission on the points that the current agreement has not worked for consumers, and so lived experience needs to be central to the development negotiation, governance, data collection and reporting for the next agreement. I would like to focus on three key things that cover the most important aspects of the interim report and our submission based on the voices of people with lived experience of mental health challenges: number 1 is centring lived experience leadership; number 2 is harm reduction; and number 3 is psychosocial supports.

So first, centring lived experience leadership. We're pleased that the Productivity Commission's interim report agreed with what we have been saying, that the knowledge of people with lived experience of mental health challenges needs to be incorporated into the design, negotiation and governance of the next agreement, including monitoring and data collection of services and supports. To ensure that this is done in a safe and meaningful way, the following would be required. Number 1, the implementation of true co-design, which is having people with lived experience of mental health challenges advising on what supports and services we want and how they should be provided.

Number 2, the funding of a support structure to implement co-design, including adequately funded national and state and territory peaks for mental health consumers, and the appropriate funding for people with lived experience of mental health challenges to be paid appropriately for their expertise. Number 3, the implementation of a robust governance structure under the agreement that supports and is inclusive of mental health consumers. The governance process must centre people's stories, values, identities, rights, needs, preferences and autonomy in decision-making. And fourth, an independent national mental health commission that is charged with holding all jurisdictions accountable for their performance.

Next point is harm reduction. We would like to see a movement away from the clinical model towards a human rights model of service delivery, particularly for people experiencing suicidality, hearing voices or experiencing altered realities. We believe that this move towards a human rights-based approach can only be achieved when consumers lead the design and governance of services to ensure that peer

values are maintained. What we don't want is to follow the path that the NDIS has taken, which is to become increasingly led by clinical services. These do not work for all people living with mental health challenges, in part because many have been abused and coerced by the very services that are meant to care for and support us.

5 Finally, psychosocial supports. The interim report and the unmet needs report have both recognised that the commissioning, provision and availability of psychosocial supports is a major failing in Australia's mental health system. The Alliance recommends co-design be undertaken to determine the types of supports and services
10 people want, what is missing and how services are delivered. Commissioning of mental health services needs to be re-balanced towards community-based and lived experience led services through the next agreement. To ensure all this occurs, we agree with the interim report recommendation that the current mental health and suicide prevention agreement is held over for 12 months with the caveat that current
15 services are provided with continued funding and adequate indexation for the additional 12 months.

We, as mental health consumers, must have time to be deeply involved in the negotiations for the next national agreement. We also need to be at the negotiating
20 table to design a new psychosocial framework. We do not want to see investment in more of the same when there is a fantastic opportunity right now to shift the dial. Thanks.

MR BUTTON: Thank you.

25 DR JACKSON: Thank you. Jen, do you have any opening comments as well or – you're all right. Okay.

MS NIXON: Yes. All good.

30 MR BUTTON: Thanks very much. So, Priscilla, thanks very much for that. I wanted to get into a couple of things with you, and certainly, the focus you've had on – you're talking about on harm reduction here, and I wanted to look at the interface now with what we're recommending or what we've suggested in the interim report
35 around an AOD schedule and getting some thoughts and views from your perspective on that and what that might look like.

MS BRICE: Our organisation wouldn't speak in detail about AOD because there is another peak body who focuses on that area, AIVL. So we would recommend that
40 you do go directly to them to talk about AOD. Jen, do you have anything to add on that one?

MS NIXON: No. That's about – yes. That's what we put in our submission, and we would leave it to them for their – yes. Their words.

45 MS BRICE: Yes.

MR BUTTON: That's okay. So lived experience leadership. You talked – you mentioned that as one of your key points and making sure – and certainly, in your submission, you talked about this chief consumer officer. Tell us a little bit more about what that might look like.

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MS BRICE: Yes. So currently, in the Department of Health, there is a chief psychiatrist, and I believe there's several others. Chief – what are they, Jen?

MS NIXON: There's a chief allied health officer.

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MS BRICE: Allied health. Allied health.

MS NIXON: Chief nurse.

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MS BRICE: Chief nurse.

MS NIXON: Chief health economist. Anyway, there's a whole

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MS BRICE: There's a lot of chiefs, but there isn't a chief that can speak directly to lived experience. And so I think what that means on an operational level is that our voices are not heard when those internal decisions are being made. There is a lived experience team, and I think that if they were led by a chief consumer, or whatever you – whatever the title would be, I think that there – the decision-making would hold more weight within the Department of Health. So that's really what we're –

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what we would like to see.

MR BUTTON: Okay.

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MS NIXON: And it could help in terms of presenting a departmental perspective, or the departmental view, or seeking comments from lived experience. At the moment, the chief psychiatrist is the one that turns up at all these – at all our events and things, seeking information, and given people's experience with psychiatry, some people feel very uncomfortable or don't feel like they will be heard appropriately. So it would also provide that bridge to get information into the department, and to get

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information out.

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MR BUTTON: And that was going to be my next sort of segue on it, because Priscilla and Jen is then thinking about, yes, you may have a role, and you've got a leadership position, but just having the position does not necessarily then connect with the sector. How do you affect both to make sure that the leadership position is being informed by the sector of people with lived experience, to ensure that what you're trying to influence around the policy, at least of design, is actually working in an effective way.

MS BRICE: Exactly. We would like to have a really strong relationship with that person and a good, you know, a working relationship, which we do have with the lived experience team at the Department of Health, but they are a small team, and I think the most senior person in that team is a director; is that right, Jen? Which, you
5 know, in the grand scheme of the hierarchy, the Department of Health, is not super senior. So I think that's really what we're missing, that voice and influence within the department but, yes, absolutely. It would be great to have a really strong working relationship with the chief, so that we can inform them so the information they're delivering internally is up to date, and what consumers want.

10 MS NIXON: And they can provide that information at that really top senior level. We would also increase priority for lived experience. So at the moment, lived experience is one section, I guess, directors as a section in a branch. And so they're still fighting for their voice doesn't even get heard at the branch level, or for their
15 work to be lifted up to the branch level, and having a chief consumer or a – whatever we want to call them – up at that level, would provide that seamless transition from work to senior discussion and senior input, and then back again. So we would, yes, as Priscilla said, see ourselves working with that chief consumer, but it would also provide a higher level of discussion and work for that section – lived experience
20 section.

MS BRICE: I think this would also be really important now that NDIS has been moved into Department of Health, because I think what we've observed is that
25 people with psychosocial disability are not – our needs aren't met in the same way that many other disabilities are within the NDIS and the broader disability sector. We are a marginalised group there as well. So I think – I know that that would be a separate part of the Department of Health, but I think it might help if there's a more senior person within the department who can advocate for our needs.

30 MR BUTTON: Yes.

MS NIXON: Yes, absolutely.

MR BUTTON: And then thinking about that more broadly in terms of the
35 governance arrangements that currently exist, and have been overlooking the implementation of the agreement, there has been – there is obviously mention in the agreement about ensuring that people with lived experience are involved in the governance, involved in the co-design. What have been some of the barriers to affect that? And how successful has it been from your perspective with people of lived
40 experience being involved, and governance arrangements being involved in some of the, I guess, implementation of bilateral arrangements. How has that gone for you guys?

MS BRICE: Under the previous agreement? Nothing. And the current one – I don't even know that negotiations have really kicked off yet. So I can only really speak from an ideal world perspective, rather than how it has worked in the past, because I haven't observed it work in the past. In an ideal world, we would be at the negotiating table with the states, territories and the Commonwealth, and to their credit, they have included us in MHSPPO, which is Mental Health and Suicide Prevention Senior Officers Group, and that meets on a semi-regular basis, maybe once every two months or so.

10 So that would probably be the mechanism by which we would be included, but then we would also like a very similar structure to be implemented at the state and territory level as well, and having been a CEO of a state consumer peak body, I suspect – and speaking to my colleagues from around the country as well, I suspect that that is not happening at the state and territory level. So it's not just what's
15 happening for us as an organisation at the public and the Commonwealth level, our relationship with them, but also across the country, because we – because of the role that we play, we don't get to see everything that's happening on the ground that our member organisations do, because they're working directly with mental health consumers. So I think it's important they're also included. And that's why in my
20 opening statement we included for them, you know, to be included in these conversations as well, not just our organisation.

DR JACKSON: One of our recommendations went to having a national strategy for mental health, which there hasn't been one since 2008, and that it be done through a
25 – you know, a meaningful co-designs process. Is that an important first step do you think before an agreement, or is it – there has been some, you know, views put, that you could just move straight to another agreement, and I guess I would be interested in your views about sort of what the risks might be on different approaches.

30 MS BRICE: We've never actually discussed that, have we, Jen?

MS NIXON: No, we haven't.

MS BRICE: I don't – no, not sure that we have an answer for you on that strategy
35 I mean, a strategy would certainly be helpful, so I wouldn't say no to that. In terms of the timing though – it's a chicken and egg question. In terms of the timing, what we really want to see is a lot of time put into co-design, so that consumers can be a part of whatever is happening, and preferably lead as well. So it doesn't have to be co-design. It could be consumer-led. Do you have anything else to add, Jen, on
40 that one?

MS NIXON: No, I think it is a bit of a chicken and an egg question, like Priscilla said. So having a strategy would set out the broad outcomes, and the broad requirement, as you know, what a strategy does, for the mental health and peer
45 agreements, I guess, which would sort of then give outcomes and measures that the health agreements have to meet, which would be a really – would be useful for that

measure, and it could also provide some opportunities for the co-design or consumer-led work to develop what the next agreements need to provide. So in that way, a strategy could be quite useful to begin with, to sort of sketch it out, tree it out, so that everyone sort of knows what we're working towards in the agreements.

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I guess if we have that 12 months period, which we support, which is that delay the agreements for 12 months, that would provide that opportunity to have the strategy, and to put all that work into working out what the outcomes we most need are, through a consumer-led process. And then the alternative way would be, I think if you had the agreements first, and then a strategy after, you would be catching up. So I don't know if you know, but in the mental health space, we spend a lot of time catching up between what the NDIS is doing, what the mental health care agreements are doing, what the suicide prevention agreements are doing, what the Disability Discrimination Act is doing, what the disabilities strategies are doing. So there's a lot of sort of reversal work happening, and if we had a strategy that could actually stop some of that and put everybody's focusing on the same output, and on the same sort of trajectory than currently happens.

DR JACKSON: Yes.

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MS BRICE: I think the question in mind would be around timing, because let's assume a strategy would take a year at least to complete. Then would the national agreement need to be pushed even further out? Because we probably want strategy first, then consumer or – at the same time consumer engagement, and then the national agreement to be negotiated. So in my mind, that sounds like more than two years but, yes, that's not my expertise. So I will leave it to you to decide how the timeline– how that would fit together.

MR BUTTON: In your submission, you talk about a public dashboard, and certainly what we've, I guess, suggested in our interim report is some wording around what a public dashboard and public reporting and accountability might look like, and we use the analogy, I guess, the similarities with the Closing the Gap dashboard that currently exists, not to say it has to be hosted on the Productivity Commission website. So that's putting that out there. And certainly what would a public – what would a public dashboard look like – or design of a public dashboard look like, in your mind?

MS BRICE: Are you asking about the process or the outcome?

MR BUTTON: Process and the outcome.

MS BRICE: Okay. Shall we start with process? I would see a dashboard actually being run by the Mental Health Commission because ultimately I see that as part of their job – in holding all jurisdictions to account for what they're doing. And so I would see us working with the National Mental Health Commission on, first of all, exploring with consumers what needs to be measured and what's going to be meaningful to us, as the service users, and then going out to further consultation to

the rest of the sector. So – yes. That’s kind of how I would see the process: that it would be led by mental health consumers. In terms of the outcomes, I don’t want to presuppose what consumers might ask for, but it would definitely have to have some human rights flags in there, such as housing and planning. So we very much see
5 mental health challenges as stemming from the social determinants of health. So if it doesn’t include human rights, I think that it would probably be flawed from the outset. Have anything else to add, Jen?

MS NIXON: Yes. The only other thing I would add is that people actually would
10 like to see how their services are performing versus other states and territories as well. That’s really key and would really help. And things that are often kept under tables like diffusion rates, restricted practices – putting them up on the dashboard puts a spotlight on them and will force people to rethink and think about, “Well, how can we get those numbers down and how can we share” – look, Northern Territory –
15 for example the Northern Territory may be doing really well. What are they doing that we could then adopt and, sort of, share some of that approach? And I think the dashboard would really appreciate – and I think it needs to be updated regularly as well. It can’t be a dashboard that’s put up and then left for two years because someone forgot to redo it or the funding ran out. It needs to be a – not a lifetime,
20 because that’s too difficult, but a regularly upkept, reliable register of actually what is going on and what outcomes are – are now seeing there.

MS BRICE: Can I just add one more thing to that too. I think that one of the things that absolutely must be on the dashboard, this goes back to human rights, is restricted
25 practices, and in particular, clinical restraint. And so this is where we get into the difficulties of implementation because there is no – currently no agreement on what clinical restraint is probably just between psychiatrists, but certainly between consumers and psychiatrists. So that would be the kind of challenge that we would have to step through to ensure that a dashboard would be – you know, would be a
30 trusted tool that’s used, because our fear is that different – other different types of restraints are trending downwards and potentially being replaced by chemical restraints, that we have no way of knowing that because there isn’t any data collected in any jurisdiction, as far as I know, maybe Victoria. So – yes. So human rights. That would be a very key indicator on that dashboard.

35 MR BUTTON: And one of the things you mentioned on the dashboard – and, Jen, you, sort of, raised it – was around social determinants and understanding that when we’re talking about social determinants, many of those things sit outside the purview of departments of health. And I guess I’m posing that because – asking a question
40 then in relation to cross-portfolio issues. How do we address those things or are they being addressed under the current arrangements and how can we do better in that space in a new agreement?

MS BRICE: I don’t think they are being addressed under the current agreement. I
45 think, like, the Closing the Gap goal – that also, too, is cross-departmental, so I see it operating in a very similar way. Yes. I don’t think I have anything else to add. Jen, you do.

MS NIXON: Yes. Well, in terms of the public dashboard, maybe not so much, but I think the interim report suggested that the Prime Minister and Cabinet take responsibility for negotiating the next agreement along with the Health Commission to ensure a cross-departmental focus is engaged. We agree with that. I think at the
5 moment we do see it in a silo with health, and there's so many other departments that need that coordination. When we had our initial briefing with the Productivity Commission – with you guys earlier this year, that was – specific discussion was what is this interdepartmental work and how can we get them engaged and responsible and involved with mental health work? And I think getting to Prime
10 Minister and Cabinet would get it into the Prime Minister's office, and they would have to actually consider how all these other things link into creating a mental – mental health challenges and exacerbating mental health challenges, and so we could – like Closing the Gap, we could sort of see real – real measures socially that have an impact.

15 DR JACKSON: So on that front, sort of a final question before I ask you to maybe wrap up with your – if you've got anything you haven't been able to say, is around – so we also recommend the release of the stigma strategy, so I think going to this point around a - sort of a whole of government approach equating to time for that is a
20 stigma strategy and producing stigma – I know even within probably the mental health system, but certainly more broadly. How important do you see that as part of this, in terms of the next – in terms of unlocking some of, I guess, the barriers to progress support and to hearing lived experience, incorporating

25 MS BRICE: Yes. That's really important to us, and we did call for that in our first submission. We are really concerned that that stigma strategy hasn't been released publicly, and, in fact, we would – we tend to use the word “discrimination” rather than “stigma”, simply because then it can be tied back to human rights. We ran a survey at the end of last year, and there was – I think it was 90-something per cent.
30 Do you remember the number, Jen?

MS NIXON: 89.

35 MS BRICE: 89 per cent of respondents, who were all mental health consumers, who said that they had experienced discrimination at some point in the past 12 months. And so we're going to be running that survey every year, so to be continued, as to whether that goes up or down, but it is extremely concerning for mental health consumers the amount of stigma that we still have to face in society. So – yes. Bring it on. Please release it, and let's take action.

40 MS NIXON: Yes. So we will be releasing our survey report in the next couple of weeks, so I will make sure that the Productivity Commission get a copy. It will be a very basic report. It's not going to be fancy, but it has got all the results in there which talk about human rights breaches as well as discrimination – discrimination
45 from the – about – yes. A very high number felt that the news media were discriminatory. So it's a really big issue that we're still fighting.

DR JACKSON: And so – yes. Any final things you would like to say? I note we’re on time, but we would like to – if you have anything else you wanted to add before we – and obviously, you know, the process remains - so I think we’ve received your submission that

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MS BRICE: We don’t have anything else to add, and I think we’ve covered it. Thank you.

MS NIXON: Thank you very much.

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MR BUTTON: We appreciate you guys appearing today, and the submission. And as we’ve mentioned, Jen, we will wait to get those survey results, when they do come through. Doesn’t have to be fancy. We don’t need to have anything fancy, but certainly it would be great to get something like the survey to – that we can use as part of, I guess, the weight of evidence around why we need to change some of the things that we’re suggesting in our process as well.

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MS BRICE: Brilliant. Brilliant

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MR BUTTON: We really appreciate your time today, and I hope you have a good rest of the day, guys.

MS NIXON: Thank you.

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MS BRICE: Thank you.

DR JACKSON: The hearing will now break for lunch, and we will resume, I believe, at 2.30. 2.30. Thank you very much.

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ADJOURNED

[1.00 pm]

RESUMED

[2.31 pm]

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DR JACKSON: Thank you, everyone. We’re now - we will now resume our public hearing for the Productivity Commission Review of the National Mental Health and Suicide Prevention Agreement. It was mentioned earlier, but for those were not present, at the conclusion of today’s scheduled participants, I will and we will ask if anyone would like to briefly appear at this hearing. Please email the address provided in the Q&A or use the Q&A function to send a message to the team if you would like to appear.

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- We also have a counsellor, Natasha Belmont, from Relationships Australia Victoria with us today for anyone who would like to chat or needs some additional support. If you would like to speak to Natasha, please email the address, again, in the Q&A or use the Q&A function to send a message to the team. I would now very much like to
- 5 call Stefanie Poole, who is a director at Kindred Clubhouse, to present to the inquiry. DR JACKSON: Thank you very much for joining us. Can I just ask you to introduce yourselves and the organisation where you're representing and then also give you an opportunity for an opening statement. Thank you.
- 10 MS POOLE: Thank you. Yes, so I'm Stefanie Poole. I'm the founder and director of Kindred Clubhouse.
- MS C. STOYLES: I'm Courtney Stoyles. I'm a member of Kindred Clubhouse, and I also work at Mentis Assist in partnership with Kindred Clubhouse.
- 15 MR C. JAMES: I'm Craig. I'm a Clubhouse member, but I'm also a member of the board.
- DR JACKSON: Lovely to meet you all. So can I invite you, if you had an opening statement, please - and then we'll have some follow-up questions, and we've got around half an hour, just for your understanding.
- 20 MS POOLE: Great. Thank you. I was going to work off, I guess, some of the points that we sent through, which - the first one is basically what is the clubhouse model? So just explaining a little bit about what we do. So we are a peer-led recovery-oriented mental health organisation. We're based off the clubhouse international model, so there's an international model that started about 77 years ago now in the US in New York. It started with consumers who were coming out of hospitals back in the 1940s and didn't feel that they had the support they needed
- 25 when they came of hospitals, so they formed their own group, which was peer-led, and that has grown over a number of years to what is now the clubhouse model.
- 30 So there's 300-plus clubhouses all over the world. Kindred Clubhouse is the only clubhouse in Victoria. You may know - or may not - there are other clubhouses in Australia. It has significantly reduced in numbers over the years due to funding and different reasons, but we are the only one in Victoria. So it is a very long-term evidence-based model, especially in other countries. Australia we are working really
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hard to get more research, but given that we don't have as many clubhouses, it can be difficult.

5 So we're submitting this - I guess, the proposal here to strongly advocate for sustainable funding for this model and to expand the model of psychosocial rehabilitation, which we know and we believe is cost-effective. It's peer-led, community embedded and it does produce long-term positive outcomes. Obviously, in Victoria, there's many challenges that we face here. Many of the people who we see are particularly not eligible for the NDIS, and even those with NDIS are
10 struggling because a lot of their psychosocial support has been cut out of their packages and they remain unsupported.

15 So Kindred Clubhouse fills this gap, and we offer purpose, connection and pathways to recovery outside the clinical system. We are a non-clinical program, but we work very closely with clinical services in our area to support people. But in saying that, we are very therapeutic in the sense that we offer people a space, and a long-term space, to recover, in a sense, and to, you know, have that support.

20 And so when we look at a clubhouse, like I said, it's internationally recognised. We provide meaningful work and social connection. It's peer-led recovery, which we'll get to. We provide pathways back into employment and education and support. And one of the biggest things is we do reduce hospitalisations and crisis intervention, which, when we are looking - for various reasons - this is important, but when we're looking at the cost that it costs society for hospitalisation, this model is cost-
25 effective.

And we're non-clinical, like I said, but we do increase confidence, self-worth, wellbeing. We reduce isolation and hospital usage, and we know loneliness is, you know, one of the big factors - the biggest factors now leading into depression and
30 other mental health issues. Re-engagement in employment and education and a strong sense of belonging.

35 So the clubhouse is very different than a drop-in centre. Like I said, the model is very specific in that we have units where members - so, for example, Courtney and Craig are representing. We have about 200 members now at our clubhouse. And we come and we work together as peers to do everything in the clubhouse. Everything from cleaning, operations in the clubhouse to - as Craig mentioned, he's on our board of directors. So when we talk about our lived experience model, which - in the recommendations 4.7, you know, peer and lived experience is one of the things that
40 was written in the review, and we believe that we provide a model that is 100 per cent peer-led. We could always improve on all of that, but we do it from the top to the bottom and bottom to the top.

45 So that's just a little bit about the clubhouse and why we are writing - why this submission was written. It also does cover off - on pages 9 and 10 in the report, it talks about the gap in psychosocial services, which is a huge unmet need, which has been written throughout the report, and we believe that we provide some hours that

meet those needs, so that's why we're here. I'm going to hand it over to Craig and Courtney. We just want to talk a little about the lived experience and the peer-led involvement in the clubhouse. If you have questions about what I just said, feel free to ask.

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DR JACKSON: We'll give you the space and then we'll - - -

MR BUTTON: You guys keep going.

10 DR JACKSON: Yes, you keep going.

MS POOLE: Okay. Thank you.

MR JAMES: Okay. I've struggled with mental health for the last 40 years.
15 Different clinical needs. Never have I found anything as strong as Kindred. And the fact that it's just peer-led. The strength to watch people grow. Disability stays at the door. This place - magic happens. The people start glowing. I mean, we help each other. It doesn't matter what it is. The peer-led experience is just incredible.

20 MS STOYLES: Yes I can back up Craig as well. I feel like it's definitely a 360 moment, and I do say it a lot. I actually met Craig coming out of using services myself, so I'd spent quite a significant amount of time in the hospital system, which is around \$2000 per night to actually be, you know, in services that might not actually work out, and when we sort of look at the clubhouse model, for what they
25 spend on me for lunch - you know, we have lunch every day, and I contribute to even cooking that lunch. It's so minimal, the cost that is being spent, but it's also costs that we have to fight hard to get as well. But yes. I did meet Craig coming out of the hospital system, and he introduced me to Kindred. And I will say, since I've walked through that door three years ago, I've not returned back to hospitals, into services.
30 The service - the last service that I had used is actually the building we're in now. And as a consumer of that service and coming into Kindred, they, you know, had supported me to get back into the workplace and through employment.

35 So I'm actually working now, you know, as their peer representative. So it does show that, I think, with the support that, I guess, Kindred provided, they provided the confidence and the skills to, you know, go back into interviews and to just do the daily things that probably were quite a struggle. It shows that it does work. To see Craig go from member to board member and to show that the decisions that are being made are for members and it starts at the top. We will one day have a decision-making meeting, and that afternoon, we will be scrubbing the bathrooms. There's a
40 huge change, and I guess, everyone does work together, and there's outcomes that are achieved.

45 But yes. I will definitely say the barriers, you know, to staying sustainable - we never know when those doors may close. We really hope that they don't, but it's definitely an ongoing fight to make sure that, you know, we stay sustainable because it does prove that it works. You know, there's a large majority of our members who

have said themselves they have not returned to the hospital system. They've not returned to use, you know, services at all or very minimal amount of services. And I think that, you know, as a comparison, is a huge, huge reduction, I guess, in that need to have to use services again. It might not also work out, but I think as well, I do talk
5 about a hamster wheel because, between crisis and discharge, there's not a whole lot of services in between that meet those needs, and I think, when we are talking about the recommendations and the unmet needs, Kindred provides that need yes.

Even from my lived and living experience, they continue to provide that need even if
10 I work there one day a week or work through – I still come as a member to unwind and have some lunch, and I think that's really important to show that, you know, three years on, it contributes back. You know, it does. It's a real community-based, peer-led, peer-run day, and – yes. I absolutely love that structure. So yes. I couldn't vouch for it more if I tried.

15 MR JAMES: Yes. And can I just add, I haven't been back to hospital since 2022? In 2023, I had 32 psychologist appointments. I've had none since joining Kindred. No psychologist, no psychiatrist, no CATT team, just Kindred.

20 MS POOLE: And you come every day.

MR JAMES: Yes.

MS POOLE: Yes. Yes. So going off of that, I do have a few stats here. They do
25 come from – some of them are from the US. Again, we don't have as much research on specific bigger, like, longitudinal studies around this, but this is – so Clubhouse International has a website that, if anyone is interested and wants to look up the evidence around this, there is so much information on their website, and this is the model that we follow. The first one is International Clubhouse research has shown
30 cost-effectiveness and found that one year of holistic recovery service delivered to clubhouse members cost the same as a two week stay at a psychiatric hospital, and that was McKay, Yates and Johnsen.

That research was done out of Massachusetts. Multiple international studies have
35 shown reduced psychiatric hospitalisation. One study found clubhouse membership was associated with a reduction in hospitalisation, specifically a one-third reduction in the number of hospitalisations and a 70 per cent decrease in the average number of hospital days. And the last one, an example as an economic model, to estimate per person annual cost saving associated with clubhouse participation – and this was in
40 the US – the model by Seidman and Usman found that the roughly 60,000 people clubhouses serve annually each year yielded estimated savings of more than \$11,000 per person or at least \$682 million a year.

If clubhouses were appropriately resourced and expanded to serve even just five per
45 cent of the 15.4 million adults in the US who live with serious mental illness, the net societal benefit would exceed \$8.5 billion and offer a drastic improvement in quality of life. So like I said, if we were to apply that, you know, Australia has significantly

less population, but you know, it's definitely something that is out there and is evidenced and researched. And from – you know, again, Courtney and Craig, you know, if we could bring all the members here to have this conversation, you would hear very similar stories around, you know, the – I guess, the reduction in the clinical services and hospitalisations as well.

Did you want us to keep going and cover off, like, the last point before – yes. So one of the other things that we wanted to really highlight is the urgent action. So in the report, urgent actions are needed before the agreement expires, and one of those is the development arrangements for psychosocial supports outside the NDIS. And like I said, clubhouse is 100 per cent an example of one of those solutions. Is it the only solution? Absolutely not. But I believe that it strongly is a solution that can easily meet that right now. It's happening right now, right here in Victoria. And so clubhouse meets that under the 4.4 draft recommendation.

So at Kindred, we can provide – so this is if everybody decided to come every single day, which, you know, that doesn't happen, but Craig does come every single day. So we can provide 988 hours of support per member. We currently have 200 members. And if they were to attend all days of operation, which, unfortunately, is only four days a week because we don't have the funding to operate seven days a week, which is 19 hours a week we're open, that's 197,600 hours a year that, potentially, we could provide right now. We're open 52 days per year of after hour services. So we operate every Saturday. We've done that since we started.

So again, we started as a grassroots organisation. I just put it out to the community in Frankston and said, "Does anyone want to start a clubhouse?" This was 12 years ago. And it has taken this long to get to this point. And we always were open on a Saturday. We started with just volunteers before we got some funding to try to actually get traction. We provide 208 meals per year to members of the clubhouse, and we currently service five council areas. So we're in the Mornington Council in Victoria, but we service people – anyone that can come to the clubhouse is able to come. As I said, we're the only clubhouse, so it makes it challenging, but we have people that travel big distances to come, if they want to.

So again, really just trying to highlight – you know, to continue to provide these benefits, we really need sustainable funding. Kindred was listed in the unmet needs analysis, which the Federal Government put that out. We are listed in that report and, unfortunately, our funding was cut completely. So we have partnered with Mentis Assist, which is another not-for-profit in our area. And we – that's through the PHN here in the southern region, SEMPHN. But with that funding, that has recently been cut as well. So we are 80,000 – that has been cut by \$80,000, and it's going to continue to reduce next year. So we – like Courtney said, we constantly are having to fight for that funding.

And what we're doing is we offer a connection between the CPS program, which is the Commonwealth Psychosocial Support program, which is a short-term program that Mentis runs. And the idea is that we work together to provide a holistic

support, meaning that these people – the clients of CPS can come to Kindred, and when they're discharged, they can remain at Kindred long-term. Unfortunately, the funding only funds for the CPS, the short-term, but it doesn't fund Kindred to continue to keep those members involved in the clubhouse over a period of time. So
5 we are retaining those people, providing support, and we're not getting the funding to be able to do that long-term, and it's not even being identified as something that is important.

10 So out of the referrals that we got from the CPS program, we can show that 83 per cent of those people, we have retained them after they've been discharged. So we can show that we are keeping people in services and, potentially, out of the hospital and out of clinical services that are costing more money. So and again, the funding does not help to cover those individuals not eligible for the CPS program as well. So I mean, like we said, Kindred Clubhouse, we do represent a return on investment.
15 It's scalable. It's impactful. It's a compassionate solution to definitely Victoria's mental health crisis. I mean, I know it's nationwide, but definitely, Victoria, we really are struggling, and we do believe, with stable funding, we can continue to be a place that people can come for recovery, connection and purpose and really service more Victorians.

20 I mean, if we could have clubhouses across the state – Queensland – like I said, there are states that have clubhouses, but it would be great to see the backing for that and to show that – you know, that we're putting, you know, funding and sustainable resources behind it so we can continue to service our community.

25 MS STOYLES: And they're long-term solutions, too. I think when we're speaking about services and hospitalisation, every service that you exit, whether it's a GP, a psychologist, whatever, you are referred on to – whether it could just be another service.

30 MR JAMES: Yes.

MS STOYLES: And Kindred is the only place that when you are referred, I guess, to Kindred, it is lifetime, so - - -

35 MR JAMES: It stops, yes.

MS STOYLES: Yes, it almost stops with that. So instead of the cycling through, you know, services – I mean, even here, we still see – we see many, you know,
40 consumers who are coming through and I have seen them somewhere else or I've seen them when I've been working NDIS or I've seen them at another not-for-profit service, and it's, you know – Kindred is that – almost that beautiful last stop on the train where you've gone through – it's a graduation service, almost. You know, you've done so much hard work, and this is the mental health maintenance, you
45 know, because we all need to have maintenance. It's – we're like cars, you know.

We need to sort of keep going but in a way that's, you know having a membership that never expires does not make someone feel that their short-term support is short term. It is for life. So you never know the – you know you're never going to get kicked out the door, and I think the thing that maybe keeps us going –

5 and hopefully you agree – but it's, you know, to stay open and to never be exited from the program, we need to have the program to begin with, and I think yes, that's the one thing that keeps us passionate and keeps us going because those doors closing would be absolutely devastating, and the thought of it, you know, is what brings us here and what keeps us going because it's – we can prove that it works.

10 And I think, you know, even from every meeting that we go to or every person that we speak to, there's always that lived and living experience for our presentation, and that has never faltered and it never will because that's, you know – that's what makes us Kindred, but – yes.

15 MR JAMES: Something so simple but works so well.

MS STOYLES: Hundred per cent, yes. Absolutely.

20 MS POOLE: So yes, that was our key point, so - - -

MR BUTTON: Thank you.

MS POOLE: Thank you.

25 DR JACKSON: How much funding do you have? Like how much are you running on a year to provide that level of service?

MS POOLE: So yes, so it was about \$330,000. It's gone down to 250,000 for

30 25/26, and from what we can – what we've heard; we don't know, that's going to further reduce next year, so that 250 is not going to stay that for long. And, you know, a fully operating clubhouse, like, at the best of times can operate off, you know – I mean, ideally maybe \$400,000. I mean, the bigger clubhouses in America can go up to the millions, but you know, again, you can work with a bit, but, I mean,

35 I say this all the time and I've said it, you know, we need to – for not-for-profits and for models like this, we need to put the resources into getting good staff, to retaining staff, to not operating off an oily rag in the sense that we just can – we make it and just squeeze by.

40 We're doing a disservice to the members who come to our organisation by not being able to even provide the operational costs for an organisation, and, you know, I think if we're running a business, it's the same thing. You need insurance. You need the operations. You need staff. You need the structure to be able to run it properly and not just think, "Oh, we're just going to throw a little bit of money towards it and

45 hope that it's going to work." For 200 people, you know, it – there's a lot of responsibility in that, as well, so we do what we can with it, but we have had to already make cuts, and, you know, it's hard. You're trying to deliver on these things

that the deliverables don't always change, but yet the money reduces and you're trying to still, you know, meet those deliverables, which is extremely difficult.

5 MR JAMES: We really don't want 200 members going back into the hamster wheel of going back to psychologists and back to hospital. It just doesn't make sense.

10 MS POOLE: Well, then it is, you know, where do they go? And that's the other thing. If we are looking at – if we have to close ever, and we have to face that, where are we sending people? You know, you have that – again, that responsibility to try to link them into other services, and those don't – like Courtney said, there's not really much out there in terms of these types of programs that are helping people maintain their mental health and that consistency. If you're coming out of a hospital, you know, some people don't even have family or they don't have the supports to actually, you know, I guess, have that recovery or access to psychologists and some
15 of the things that they need. So yes.

MR BUTTON: Couple of quick questions for you. First one, hopefully a nice and simple one: have you had any independent evaluations done on the program that give some evidence in relation to how well and how effective the model is, how well
20 it's working? For you guys in particular, I know that you're citing the research and the evidence that's in the US, but is there – have you had some stuff done locally as well?

MS POOLE: Yes. So we have had occupational therapy students that work with
25 Monash really try to work with us to get some information about the clubhouse, so one of them just finished a report which we did put in with other submissions, so this has been an ongoing process, but, you know, looking at, you know, Kindred Clubhouse and the model itself, and then we just had another student who graduated. Unfortunately her research isn't available yet, so it is a slower process. We also are
30 working closely with Deakin to try to get more of, you know, a theory of change model and looking at the stories and trying to actually collate those stories.

Queensland Stepping Stone Clubhouse does have a bigger report that they have recently – and this has taken years. I mean, they've been around for a long time, but
35 that's really all in terms of Australian research. And again, we are trying to leverage off maybe getting some grants or students to try to help do some of that independent research, but again, it's just trying to find the right avenues and get – again, you know, some of it we may have to pay for, but others we are trying to work with volunteers or people who might be able to help us so that we can gather that for even
40 a stronger case, obviously, for Australian research, as well, so yes.

MR BUTTON: Anything that you can provide to us in that sense, Stef, would be great, and is going to contribute to understanding the broader picture around the clubhouse model and the operations, etcetera, because - - -
45

MS POOLE: Yes.

MR BUTTON: we're going down a path that you've seen in our interim report, we're going down the path of saying that we need more evaluations, and those evaluations undertaken in relation to initiatives that sit in the agreement and those evaluations then being open and transparent and available to the public, that's – that

5 would certainly go towards supporting that process so that we can demonstrate to say, "Look, we're actually using evidence and real life evidence that's in the system to determine that this model actually works, and so that's why funds should go to those models because the evidence suggests that they work."

10 MS POOLE: Yes. Yes.

MR BUTTON: Anything you - - -

MS POOLE: How can we – I mean, like, I – obviously I can check with Monash,

15 too, some of it is, but can we send that to you still or how do we do that?

MR BUTTON: You can send that to us, Stef, yes.

MS POOLE: Okay.

20 MR BUTTON: That would be great.

MS POOLE: Great.

25 MR BUTTON: The other question that I did have is in relation to you talked about your connection with the NDIS providers, connection with hospitals. How does your referral pathway work? What does that look like, and what's that – has it taken a long time to develop those relationships, as well, within the model?

30 MS POOLE: Yes, so our – again, it has taken a long time to develop those relationships over time. Again, we work really closely with the CAT team, Peninsula Health, which is down near us. So – and again, we go out. We do a lot of outreach to, you know, APARC, as well, YPARC and a lot of the programs that would be the referral sources a lot of times. We also – like, through NDIS, yes, we

35 have people come down. Once people get – I feel like once people start knowing about it, it almost just organically spreads a bit. We also have the locals down near where we are, Frankston locals, which was obviously set up as part of the – you know, part of the agreement in some ways. Sorry.

40 And yes, we work closely with them as well, and they send people through. Unfortunately, you know, when those were opened, I think they do provide support but they don't provide the same supports, obviously, as what the clubhouse can provide in that longer-term support, as well. But, you know, we do have a lot of referrals from – once people, like I said, get a hold of it and hear about it. Sometimes

45 we have to actually – we have, like, too many referrals, to be honest, so – which is a good thing, but we have to be able to maintain that and, you know, provide that support, so - - -

MR BUTTON: And you mentioned some of the – sorry. Did you want to jump in as well, Courtney?

MS STOYLES: No, I just want to – going to say, yes, especially even from a
5 Mentis perspective, too, the referrals – we were actually just speaking this morning about how we have a lot of – it's quite a bit of backlog just in between our cross-referral process, so our goal is to refer Mentis clients over to Kindred for their long-term maintenance of their mental health. But yes, we've definitely found, especially
10 even just this morning it's popped up in a meeting that we've – you know, that the waiting times are starting to get a little bit – and mental health has no waiting time.

You cannot put working time on it, so yes, that was definitely a bit of resistance that we've noticed. You know, it's definitely a barrier that, you know, with all these referral pathways because we do get the referrals through Peninsula Health and we
15 speak with the Frankston locals and we speak with Mentis Assist, and there's – you know, when the support workers bring their clients to Mentis, that's – I think support workers are our biggest word of mouth referrals.

MR JAMES: Yes.
20

MS STOYLES: I think when they come here, they're like, “Oh, I've also got a bunch of other clients.” And I used to work in NDIS, so you do sort of get to know your community and get to know who's working who and yes, that's – I find that that's definitely a huge word of mouth part of the referral process, but yes, waiting
25 times are probably the biggest barrier that we're finding, and we don't want people to wait, but like Stef said, working with what you have, and what we have, you know, can be minimal at times, but, you know, we do make it work. So yes consideration.

MR BUTTON: Conscious of time. We're about to run out. I was going to just touch in on that around the referral process and the commissioning arrangement and what that looks like in terms of, I guess, then some of the revenue streams for yourself, Stef. Is it then being, I guess, a provider where some of those services purchase those services from - other services from you that they're not able to
35 provide but you guys can do through Kindred? Is that - how does that work as well through that whole referral process?

MS POOLE: Yes. I mean, yes, like, that can be - some clubhouses have gone to that model. Again, I mean, I think sometimes it's an ethical thing as well. If you are
40 exchanging money, it becomes a different exchange, and the way that clubhouses have operated, the value of a clubhouse a lot of times is that there is no, like, money exchange, in a sense, so if it's a package and all of a sudden you lose the package and there's no money, can you still come to the clubhouse?

45 And so there's a lot of nuances, I think, within that when we're making decisions on, like, where the funding sources potentially come from, but ideally, a clubhouse

would have a few different, yes, funding streams to be able to sustain itself. So those are all things that, you know, we have - we try to consider and look at, but - yes.

5 MR BUTTON: Look, really appreciate your time appreciate you telling your stories and telling the personal tale of going through the process and what it means to you both as well, so thank you very much for sharing that with us today.

MS STOYLES: Thank you.

10 DR JACKSON: It's an example, clearly, of a service that, yes, delivering a lot of value in the community, so thank you very much.

MS POOLE: Thank you.

15 MR JAMES: Thank you.

MS STOYLES: Thank you.

20 MR BUTTON: Now we have the Queensland Alliance for Mental Health. Emily and Chloe, I think, are going to join us. How are you, Chloe? Can you hear us?

MS C. JESSON: I'm good. I can hear you. Can you hear me?

25 MR BUTTON: We can. Thank you.

MS WOLTER: Hello, Selwyn. Hi, Angela.

30 DR JACKSON: Hi. How are you?

MS WOLTER: Great. How are you?

35 DR JACKSON: Yes, we're doing well, thank you. It's been a great first day. I'm not sure if you've been listening in.

MS WOLTER: We were just listening to the clubhouse, yes, present to you, which is great, because we also work closely with the clubhouses, so it's good to see them in the room and having the conversations with you directly.

MR BUTTON: Excellent. So we want to give you guys the time. So you've got a half an hour slot now to - for you to talk through your submission and some of the things you want to focus on. And for the transcript, obviously, what we want you to be able to do is to say your names, the organisation, the position you hold, so at least
5 we can record that as part of the process as well, but I'm happy to hand it over to you guys

MS WOLTER: Sounds great. Thank you so much. Well, my name is Emily Wolter. I'm the CEO here at Queensland Alliance for Mental Health, and I've
10 brought along Chloe Jesson alongside me today. Chloe is the deputy CEO here at QAMH. And yes, as you said, you have met with us before, and I know we had quite a robust conversation when you were in our office some months ago. So as to not - - -

MS JESSON: Yes, it was a great conversation. So as to not bore you or to just remind you of what we've already discussed, we really tried to find some additional member data to kind of fill out or to further demonstrate the effectiveness of our sector and to, I guess, paint the picture a little bit brighter around what it was that we're advocating for within our submission regarding the interim report as well.
20

So I know that you're meeting with CMHA later on and you've just met with the clubhouse, so I think you are quite familiar with what we mean when we talk about community-based mental health settings, but essentially, just to remind you - and I think that this is great for the transcript as well. To remind you that community-based does mean the mental healthcare that's outside of hospital walls.
25

So what's so strong about the community mental health setting in sectors that we are place-based, so especially because here in Queensland, 40 per cent of our residents are in rural and regional areas, and we have such a diverse population as well. Our services are able to provide that care and support in a place-based way, meaning that they fit the needs of the specific communities that they serve.
30

So our message really does reflect what you've largely already written about in your interim report. Strategic thinking and a revised approach with tangible and data-driven outcomes is essential. So we highlighted key recommendations for immediate implementation while we work towards the 2027 date, and we do have recommendations that allow for immediate implementation to enable meaningful codesign, stronger sector leadership and better planning, but our recommendations immediately address some of those significant and imminent challenges the mental health system is already facing.
35
40

So as I said, we brought some more data to you today to discuss today to further illustrate or demonstrate the effectiveness of our sector. Within our submissions, we've written key recommendations, but 1, 3, 4, 5 and 7 from our submission really

aim to decrease the fragmentation, unclear accountability and lack of data-based infrastructure for the mental health system.

5 And I think it's really important for us to reiterate that in community mental health, we have less resources, yes, but it also means we have less capability or internal capacity and resources to really demonstrate the effectiveness of our sector, because we don't have that same capability of capturing data and telling member stories in the same way that other services might be able to do, including in the social services.

10 And because we're not clinical settings, in some ways, our data might illustrate something that's quite opposite of what an effective mental health service might say in a clinical setting, because in a clubhouse model, for example, many times you want those clients to return to the clubhouse, because that's what is keeping them well and in community, and so it is hard to kind of further demonstrate the
15 effectiveness of our sector without that guideline around what data you're wanting and what shows, yes, that effectiveness. I love to see

DR JACKSON: I think that is a really important point that you just made there, and I'll just - I think the previous - the clubhouse budget of three hundred
20 thousand a year, finding a budget for an evaluation which can easily cost 150, 200 thousand, and that's a basic one. You can see why that evidence base isn't necessarily there. So I get that point.

MS WOLTER: We know some of that data, but even Chloe and I were just
25 messaging, because when they said the figures you go wow, and if you could step into a clubhouse and see how brilliant the work is that they're doing and the way that they can work with such minimal funding and create such incredible impact is outstanding. We quickly looked up the Stepping Stone Clubhouse's report that the previous representatives had mentioned, and the data that they were able to provide
30 was that 41 per cent of brand-new members to the clubhouse had been in hospital for mental health in the six months prior to signing up as clubhouse members versus only 16 per cent of existing clubhouse members returning to hospital within six months of them becoming members.

35 So that helps demonstrate the decrease in hospitalisation with such minimal funding, and these are the kind of pieces that we're talking about that our sector really doesn't have always that capacity to really grab that data, but Stepping Stone was funded to collect some data and to illustrate that.

40 I just might read off, and then we're open to some questions. I just wanted to read off some other data that we were able to grab from our members within the last few months. So this is all again community-based members of QAMH. So Youth

Insearch had reduced severe psychological distress and suicide risk for 70 per cent of their participants through their work. Brisbane North PHN Safe Spaces averted nearly 900 emergency department presentations annually, and this saved over \$9 million. Flourish Australia delivers a \$3.27 return per \$1 invested in their services.

5 And Oasis Townsville generates \$3 per \$1 through improved participation. We can send all this data to you if it's helpful as well.

And then when we're talking about economic returns and the reduction of pressure on acute care systems, again, a few examples for you. Flourish Australia's peer-operated service returned 3.27. I just read this one out, but \$3.27 for every \$1 invested. Oasis Townsville – so that's a community hub for veterans and their families – they reported a \$3 return on investment for every \$1. So these findings here in Queensland also align with the national evidence as well. So part of our recommendation, I think you can hear, is that government must bring community

10 operated service returned 3.27. I just read this one out, but \$3.27 for every \$1 invested. Oasis Townsville – so that's a community hub for veterans and their families – they reported a \$3 return on investment for every \$1. So these findings here in Queensland also align with the national evidence as well. So part of our recommendation, I think you can hear, is that government must bring community

15 mental health to the centre of planning, funding and evaluation, but also ensure that they have the funding and the tools to deliver, measure and scale the programs that already are working, and are in place.

Policy-makers and commissioning bodies must invest in this infrastructure and evaluation frameworks, and then there's also from our sector that the funding models are longer-term, and they're flexible, so that they can actually meet the needs, and that the services can innovate and adapt as the needs are evolving. I guess the two other main asks are that we work intentionally to embed First Nations leadership, and cultural safety at the centre of reform, and fully fund the 2025 to

20 Policy-makers and commissioning bodies must invest in this infrastructure and evaluation frameworks, and then there's also from our sector that the funding models are longer-term, and they're flexible, so that they can actually meet the needs, and that the services can innovate and adapt as the needs are evolving. I guess the two other main asks are that we work intentionally to embed First Nations leadership, and cultural safety at the centre of reform, and fully fund the 2025 to

25 2035 suicide prevention strategy, and fully implement the national mental health workforce strategy, but then also that we reiterate our recommendation round the fifty-fifty funding split for psychosocial supports outside the NDIS.

So that's a fifty-fifty split between Commonwealth and the States. Those were kind of our key pieces of data here. We have a little bit more about ROI, so return on investment and economic impact of our sector, but Chloe and I, yes, are here to answer any further questions, or to, yes, get into any further details of what I've just described or anything else that comes up for you as well.

30 So that's a fifty-fifty split between Commonwealth and the States. Those were kind of our key pieces of data here. We have a little bit more about ROI, so return on investment and economic impact of our sector, but Chloe and I, yes, are here to answer any further questions, or to, yes, get into any further details of what I've just described or anything else that comes up for you as well.

35 MR BUTTON: Great. Chloe, did you have anything to add before we ask any questions?

MS JESSON: I think just the only thing with the funding, and the way that funding – that flexibility – we recently did a regional roadshow, went up to Bundaberg, and one of the big things that we found in that region was that young people, there's very

40 MS JESSON: I think just the only thing with the funding, and the way that funding – that flexibility – we recently did a regional roadshow, went up to Bundaberg, and one of the big things that we found in that region was that young people, there's very limited supports available, and while some of the adult services can support 16 and above, there are 15 year olds trying to access this service that they are simply not permitted to support, and the wait list for the headspace out there is, you know, astronomically long. So there's actually – the strictness and the lack of flexibility

45 MS JESSON: I think just the only thing with the funding, and the way that funding – that flexibility – we recently did a regional roadshow, went up to Bundaberg, and one of the big things that we found in that region was that young people, there's very limited supports available, and while some of the adult services can support 16 and above, there are 15 year olds trying to access this service that they are simply not permitted to support, and the wait list for the headspace out there is, you know, astronomically long. So there's actually – the strictness and the lack of flexibility around funding, it's not necessarily just that they need more time with people, but sometimes who can access the service and what period of time can sometimes be that they live a street out of the area, or that they're two months too young, and there just

needs to be a little more flex to make it appropriate for the needs of that particular area, and what other services are available or not available in that area.

MR BUTTON: Thank you. We're going to go back to the funding piece. I know
5 we have some conversations about funding when Stephn and I were there with you
guys in Brisbane a while back, and the purpose of this, I guess, for – particularly for
you guys, is to getting it on – to get it on record in respect of some of those, I guess,
barriers that exist in relation to contractual arrangements with some of your
members, and what that does in terms of impact on services, and really about where
10 it's – where you've got members being funded for short periods of time to undertake
things, and what that then looks like for continuity of service for looking at support
in community, and then ongoing, I guess, thinking about – for services themselves,
thinking about where they're going to get the next funding round that then supports
the continuation of activities for individuals in – and families in community.

15 MS WOLTER: Yes, of course, yes.

MR BUTTON: It's a bit longwinded.

20 MS WOLTER: Yes.

MR BUTTON: Sorry.

MS WOLTER: Well, it's hugely problematic for our sector when there's short-term
25 and inflexible funding. As we're still – I mean, you could hear that highlighted issue
around the lack of data and resources to collect that data for our members, but to try
to innovate and adapt the needs of the population while also trying to fight for
funding for just next year's – yes, next year's funding, it not only interrupts any
cycles of care, but continuity of care, and especially with the staff that our sector
30 does hope to attract. It's nearly impossible when those short-term funding
arrangements are in place. We have such a huge workforce shortage already, but to
try to attract people into year-long contracts is not only impossible, but it's not best
practice for anyone utilising those services either, and something that's so strong,
and you will hear from the clubhouses, for example.

35 I'm using them as I know they were just speaking so passionately about what they
do, but because clients are coming and seeing those familiar faces, and they're
building community, that's what is really a strength of a clubhouse. So if you can
flip that model and go, well, if the staff aren't presenting as the same, well, they're
40 not building community with the client, so with patients that they might serve, that's
not as effective as it can be. So our sector is very strong in asking for longer-term
and flexible funding models, so that they can modify and adapt, and as the workforce
increases, I guess, their knowledge and capacity and capability, we may or may not
need the same FTE that we did at one stage. So that's where that flexibility and that
45 importance of flexibility also comes in as well. Chloe, I don't know if you have
anything else to add.

MS JESSON: Yes, I think current funding is quite strict in terms of output. So there's an expectation that you will get X amount of funding, and for that amount you need to see X number of people and X number of times. And that means you need a certain amount of staff, and you have to pay those staff a particular amount,
5 and it doesn't really leave a lot of funding left over for supporting that workforce for appropriate supervision, appropriate professional development. That's not really available if you would like to keep your contract, and you would like to keep your funders happy, you need to be kind of this output focus, which is not necessarily in line with the outcomes that we're looking for.

10 So that – there's also a tension there too, that to keep the funding, you have to be getting these outputs out, but to do that, you're not really left with any fat in the budget to really support the workforce to be able to do any of this evaluation, to be able to improve the infrastructure, anything like that. It's all very much on those
15 outputs, which are not necessarily recovery-focused outputs. They're generally a K10, and you have to have the two of them, and they have to be a particular number. It's quite rigid, yes.

MR BUTTON: Do you have members – do you have places across the state where
20 it is working better?

MS WOLTER: Yes.

MS JESSON: Yes.
25

MS WOLTER: And you might have more to add here again, Chloe, but the larger service providers tend to have a little bit more fat around their funding, and more FTE, which means that they can support, I suppose, the internal capacity-building within their teams. So one point I wanted to make there was, when we talk about the
30 importance of peer work or lived experience workforce, for example, what's many times forgotten is that you need to embed funding to actually develop that emerging workforce as well, and if that's forgotten, it's not only ineffective, but it can be very detrimental to not just the workers, but the people who are using the services, and it has adverse effects on all staff within that service provider.

35 So I did want to make that point before we go on to what's working well, but I would say probably the larger providers or those, of course, with longer-term funding, or those with more creative approaches around their funding models, who have been able to attract some key players or staff members, I suppose, within their
40 organisations, who can further develop their staff. What is constantly lacking, or what people need more of is supervision within their roles and, yes, that leadership capability. Chloe, I don't know if you have anything else around what's – who's doing it well.

45 MS JESSON: Yes, in terms of things that work well, and I think I mentioned this one when you were – when you met with us, Selwyn, but what I tend to find is there are these fabulous pilots that are run for short periods of time, and they always seem

to be really fantastic and have brilliant outcomes, and then they're never re-funded again, and one example of that, which thankfully has been re-funded for a short period of time, is the Brisbane North Safe Spaces, where in terms of outputs, there wasn't really a focus on outputs. People could access the service entirely
5 anonymously. You know, you didn't have to collect their name, any demographic information.

So there wasn't really an administrative burden on ticking boxes, and there also wasn't a particular number of times you had to, you know, have people turn up. You
10 weren't trying to chase people to get into the service, there was no referral requirement. It was probably as flexible and as open as you could get. The doors would open. Whoever turned up, turned up. They were supported in the way that they needed to be supported, and data was collected just around, you know, "Would you have gone to hospital if not here, or where would you have gone?" and hospital
15 was one of the options, and just a SUDS was done, so a distress score was collected kind of at the beginning and at the end, and they collected all of this phenomenal data on people that would have gone to ED if not there, and also were able to show a reduction in distress, but what people were able to access while there was entirely up to them, whether that was peer connection, whether it was a group conversation,
20 whether it was some arts and crafts, it was very much open to whatever they needed, and, unfortunately, it was a pilot and it's a short-term – it's a short-term solution.

MS JESSON: And that's the one that I read out before, that's the one that I've read in 900 emergency department presentations in the year, but you can see where
25 there's that challenge that, if people come in anonymously, sometimes there's a lack of data around it, but we know it's working, but it just mightn't fit the same kind of traditional model that government might be seeking or outcome measures that government might be seeking to illustrate effectiveness.

30 MS WOLTER: Yes.

MR BUTTON: Thinking about – and not to show my bias, but understanding that Queensland is a very decentralised state; people live all over the place in
35 Queensland, thinking about your members in other parts of the state, and you mentioned the 40 per cent, and, you know, across Queensland anyway, but certainly looking at, then, different models where you – where there's a need to think about different approaches in different geolocations across the state, are there other things that are coming up from your member base about what that might look like in other places as well, and the need to think about the flexibility of funding and
40 arrangements, etcetera.

MS JESSON: For sure. Recently went up to the Gympie region, and what they're doing is organising in their local Aboriginal communities out there, they're doing home visits, and what they're doing is kind of going out there and saying, "We're

going to be out in this house, you know, for the day,” kind of, “Get all of your friends and family that need support to come over, and we’ll do it all in one day while we’re all there together.” So they’re doing that kind of outreach, parachuting into a community or into even a home or a local neighbourhood centre, and getting everyone in that community just to turn up on that day to get the support that they need, and so that outreach model is something that I think our sector does really well in being able to go where people are and trying to coordinate supports for that local area. Again, that’s very costly, though, you know, the transport costs, potentially, you know, the first time you go out you have to go out with a colleague for risk assessment purposes. It’s a costly way of doing things, but the members that are doing it are finding it probably the most beneficial way to access those more regional remote communities.

MR BUTTON: Yes.

MS WOLTER: And kind of in that same tone, there’s a First Nations community that I met with not long ago who were doing the model quite differently. Like you would never seek funding for this, traditionally – and they hadn’t – but they were doing this model that worked really well, where they were just a group that went to the gym, they went to churches, they went to the park, and that’s their – that was their way of hosting these mental health support groups, essentially, but it wasn’t marketed as such. You wouldn’t even see a sign for it and assume that it was a mental health support service, but that’s what it was. So their model was very much so meeting people where they’re at, and they were doing it free of charge, but needing funding ongoing, because there was such demand for it, and that’s something that the community sector just does, and it works, and so they keep on doing it, really.

MR BUTTON: Interested in your commentary about the fifty-fifty split for psychosocial support.

MS WOLTER: Yes.

MR BUTTON: I mean, looking at it from a Commonwealth perspective, I guess the Commonwealth Government would probably say, well, the gap has now existed because of the fact that we’ve got to the NDIS, and we’ve had state and territory governments sort of opted out because of NDIS, and then contributed to that. Now, this notion of a fifty-fifty split, I guess, I’m interested to know where it’s come from, and what’s the idea around that.

MS WOLTER: That’s – it’s a harder one to answer. We’re kind of going someone needs to do something and fund the gap here; the gap of psychosocial supports outside of the NDIS. There’s 92,000 Queenslanders without the support that they need currently, and I think it’s about half a million nationwide without support that they need, and so in working with the other states and territories and the national peaks, fifty-fifty funding split is the closest they may come to us. Fair is fair, if

someone needs to fund it, and it's a human rights issue; it's our responsibility, so split it fifty-fifty. I don't know if, Chloe, you have anything else to add to that.

5 MS JESSON: I mean, yes. Look psychosocial supports has always, unfortunately, sat in the middle, and I think it is unfortunate, because it has meant that each could kind of say, well, it's not our responsibility, it's theirs, and vice versa. In Queensland, our State Government do fund individual psychosocial support programs, and PHNs fund psychosocial support programs. So, currently, both are contributing to psychosocial supports, and so that is the case – that is reality – and so 10 both need to uplift those supports. I think it's – yes, here – and I think Queensland, we are quite fortunate, our State Government has funded fairly well in psychosocial supports compared to other states, but, still, it has been, to date, both governments that have been contributing, and so we don't think that that should change. We just would like to see more funding in that space to fill that gap.

15 DR JACKSON: It would be interesting to hear from your, as a peak's perspective, there's a lot of discussion around the impact the NDIS has had in terms of a reduction in effort from the state governments and spending, what that – sorry – what that looks like for your members. So I think it's hard to get a handle on figures, it'd 20 be fair to say, but I'm assuming that, from a members' perspective what those look like; it would just be good to understand.

MS WOLTER: I think we might have discussed this a little bit, so when you were in the office, as well, about the distress that that has caused, and the foreshadowing 25 of the impact on our sector, where the NDIS is just such a mess at the moment, and so underfunded, and that there's already so many people who are missing out on the support that they need, and that should further people miss out on that and services become defunded or are unable to provide the NDIS services that they once were, that actually means that there's going to be more of a burden on our sector in 30 community mental health, because a lot of that weight, I suppose, is already carried by our sector, and it will just get heavier as the NDIS becomes more of a mess and less structured and organised as far as who's funding what and why.

I think it's also – my perspective has been with the Queensland Government, in 35 particular, it's been quite confusing, I think, for government to understand who's funding what and why, and so when you say something like “psychosocial support” or “NDIS”, sometimes it's like, “Yes, Commonwealth, not my problem,” and it is our problem, and that's probably where some of that fifty-fifty ask has come from in that it's shared responsibility, and these are our people regardless of who's funding 40 it, but I think what we've been trying to further explain, I suppose, back to government is that psychosocial supports do need funding from us at a State level as well; that Commonwealth isn't funding it all, and while Queensland has been generous in, I guess, the larger landscape of the nation's framework and who's funding what.

45 Queensland has funded individual psychosocial support, but it's still such a fragmented approach, where we have, you know, Queensland Health quite

supportive of psychosocial support funding and with the greater understanding of the importance there, but it doesn't mean that it's adequately funded or that there's an understanding from government at, well, the state and national level around who needs to fund it. I would say our member experience has been many members have
5 pulled out of NDIS service provision, and many members are pre-empting the effects on their services, if not already felt, that will be felt once NDIS continues to just kind of carry forward with this really messy, messy and scary, I suppose, trajectory that they're on.

10 MR BUTTON: And I'm assuming no different to the story we heard from the Clubhouse guys and irrespective, clients are turning up to services to access services - - -

MS WOLTER: Yes.

15 MR BUTTON: - - - not worrying about eligibility requirements of being in a particular program, but they're expecting that because the provider's been with them and supported them, they're going to access the service anyway, and our - and your members would be still obliged and still in that being in the care space, you're going
20 to support individuals who walk through your door anyway.

MS JESSON: And, look, a lot of them, if they have an NDIS package, whether or not they can spend the money - so they may have a package, but there are limited services available in the psychosocial space to be able to spend that money, because
25 the viability is just so low for an organisation, but because they have the package, they are now no longer eligible to access the Commonwealth psychosocial program. So they might turn up, and it's the only service available to them, but because they have that package above their head, they now can't access that service. So it's really difficult to explain that to a person that, "You obviously need this support. There's
30 no other support that you can access, but because you've got this money sitting in this budget, you can't actually access this service." Yes.

MR BUTTON: I'm conscious of time, and I want to make sure, at least, if there's anything else that you guys want to get across before we finish up, or anything else
35 that you want to focus on that we haven't touched on today, give you the chance - an opportunity to do that now before we close off.

MS WOLTER: I feel like we've covered most of what I've - - -

40 MS JESSON: Yes.

MS WOLTER: - - - got behind me here. Chloe, is there anything else from you?

MS JESSON: No, nothing else from me.

45 MS WOLTER: Okay. Great.

MS JESSON: Right on time.

MR BUTTON: Excellent. Well done.

5 MS WOLTER: Like we rehearsed.

DR JACKSON: Thank you so much.

MS WOLTER: Thank you.

10 DR JACKSON: Thank you, both.

MS WOLTER: Great to talk to you. Thank you very much for the opportunity.
Good luck with the rest of the afternoon.

15 MR BUTTON: Thank you.

DR JACKSON: Thank you.

20 MR BUTTON: And we have Chris?

MR BUTTON: Great. Thanks very much for joining us this afternoon.

MR STONE: No. Thank you. This is great.

25 MR BUTTON: And provide you with an opportunity to talk through, I guess, your
submission and certainly to focus on a few key things - - -

MR STONE: Yes.

30 MR BUTTON: - - - from your perspective. We want to give you a half-hour now to
talk through the submission and certainly some of the things that Suicide Prevention
Australia are keen to focus on, but before we kick off, if I can ask you to, for the
transcript, state your name and title and organisation you're representing, and then
35 we can – and then I'm happy for you to go into your opening statement.

MR STONE: Great. Thanks. My name is Chris Stone. I'm executive director at Suicide Prevention Australia. Look, in terms of my opening statements, I don't want to take up too much time because I'm really here to answer your questions. I did want to just highlight three points from our submission, and that is around funding
5 and workforce and research. So on the first point, with funding, I won't go into too much detail because I'm saying things that we and our sector have been saying for years, but the problem is not yet solved, so we need to keep saying them.

10 Critical issues around funding is transparency. It's hard enough even over the, sort of, mental health and suicide prevention space to see what money is allocated where, but when you're looking specifically at suicide prevention, it's never accounted separately. We really don't know how much money is going into after-care services, how much money is going into postvention services. It's a critical baseline piece of information of what is the actual activity. There are also issues around measuring
15 outcomes as well, but at least there's a baseline. We would like that transparency.

The other issue around funding is, of course, critically the contractual arrangements for the not-for-profit sector, and timeliness, length of contracts and indexation are the three key points there. It's obviously very difficult to run an efficient service if you
20 don't know within six months whether or not you are getting recontracted or getting a new contract or not getting a contract, and it's simply – it makes for a less-efficient use of government money. Similar thing with length of contracts, a longer contract - as long as the agreement allows the service to operate more effectively and use the money more efficiently. And then, of course, indexation is just critical, in terms of
25 making sure that the actual same money in real terms is given to services to do the same job. So, as I say, funding is fairly straightforward, and we've said it before, but we would love to see that highlighted in the Productivity Commission's, kind of, final report.

30 Workforce is often described as the elephant in the room in our sector. It's the thing that our members are always talking about. You know, we have for a long time been advocating for a suicide prevention workforce strategy, but now what our members are telling us is that we're at the point where we're kind of beyond the point of the need for a strategy. We actually need an initiative which would incorporate that
35 strategic planning, but would also have funded actions in it. We know, roughly speaking, what we need to do, and so we would like to see an initiative embedded in the next agreement to make sure that the workforce is actually capable of delivering what we want a national agreement to produce, and we've outlined in our brief specific things that would need to be in such an initiative.

40 The final point is one I want to talk about because it might seem like an odd fit, and that is funding for research. And I understand that a national agreement would not normally address this issue. The reason why we've been bringing it up is because there is a strong focus on best practice and the evaluation to achieve it in services.
45 As you're aware, that sort of evaluation is not simple. It's not straightforward. It's not something you can just throw into a contract and say, "Make sure you run a survey." In practice, it is a whole project, in itself. It is frequently run by researchers

– qualified researchers in the area, and so we need that kind of research cohort – that cohort of researchers to be able to do the evaluation that leads the best practice.

5 Now, in many of the national agreements that is effectively delivered because there are research funds. You know, if you look at, say, Closing the Gap, you have things like the Indigenous Health Research Fund, \$160 million, as well as a range of other research grants. If you look at, say, the National Agreement on Housing and Homelessness, you have organisations like AHURI, again, dedicated funded research institutions. When you look at suicide prevention, as of June this year, you do not
10 have any dedicated research on suicide prevention.

We did have the National Suicide Prevention Research Fund, but funding of that has ended in June, and so I feel like that whole focus on evaluation and best practice and the move to improving practice really depends on actually having a research fund
15 sitting there, and if it doesn't fit in the agreement, it at least needs to be, kind of, a condition that needs to occur somewhere in order to make sure that the next national agreement is as effective as we want it to be. Those were, I feel, the top three points, but really have – obviously, we made a range of other points in our submission based on what we've heard from our sector. Really happy to talk about anything else that
20 you wanted to talk about.

MR BUTTON: Thanks very much. If we can start with the – if I start with the workforce staff. And knowing that there has been some work that has happened through the National Suicide Prevention Office and we're now suggesting to focus
25 on a suicide prevention schedule specific within the agreement, are these things which – I guess is a chicken and egg. Which should come first? Should the – should we – are we suggesting – or are you suggesting that the workforce components come prior to a schedule or are they in the schedule or what's the sequencing? How does the sequencing, sort of, operate, in your mind anyway?
30

MR STONE: Look, in an ideal world, we – we're aware of the fact that with the Productivity Commission's recommendation of an extension of the agreement – if it was embedded in the suicide prevention schedule, then we're talking a little while before we actually see it operate. So in an ideal world we would actually like to see
35 it come first. I am not sure about whether that really is realistic. And so I guess, at the very least, we would like to see it embedded as an action within the suicide prevention schedule in the next agreement, but I think in an ideal world we would actually like to see it as a kind of – as its own project, as a precursor arrangement to make sure that things – the sector is strong enough when the agreement starts to do
40 what the agreement wants.

MR BUTTON: Okay. So we would focus on those things and – and these are the things that – what you're suggesting is those things that have been built into the new national suicide prevention strategy, which has been co-designed with the sector –
45 there are some elements of that that should happen straightaway. If we're suggesting a pause of 12 months to design a range of things, including a national mental health strategy,

during that time there are some things in the national suicide prevention strategy that can happen now – or start happening now.

MR STONE: Yes, look, absolutely. The research that we've done and seen is that
5 we're talking about – around about a third of our sector who are either in burnout or at high risk of it. That's only going to get worse, and so we're really concerned that we don't want to end up in a situation of having a sector that is burnt out when the agreement starts. So – yes. Having a kind of project in the lead-up to the national agreement means that the sector starts strong when the agreement starts.

10 MR BUTTON: Okay. That makes sense. And the research one. Keen to – can you expand on that. We have heard some submissions today and had some people coming along from different organisations today talk about that research and the importance of research in the overall agreement. Again keen to get a sense from you,
15 is it something that should be in the entirety of the agreement that focus on suicide prevention? Are you suggesting something that just is in the schedule on suicide prevention itself? How do you see that sitting in the broader context of the agreement?

20 MR STONE: Yes, absolutely. I think, again, it's a similar answer: that we have just recently lost the research funds. It would be a real shame to have, you know, two years of, you know, no further money going into research over that period, particularly given that there are, no doubt, a whole bunch of lessons that have been learned in the current agreement that we could be drawing on with research. So we
25 would actually – we would like to see research funding immediately. As you're aware, Suicide Prevention Australia administers the fund. We don't conduct any of the research. We don't use that money, but we administer the money, and on the advice of research experts, we distribute that money to research projects. So the system is there. If the money comes through, we could restart it tomorrow, and we
30 would like to be able to do that.

MR BUTTON: And similar, I guess, in other spaces - and I'm drawing on experience here from community control sector, where being a former chair of the Lowitja Institute, we would co-design the research agenda with community and that
35 would then form the basis of what the funded research activities would look like.

MR STONE: Yes, absolutely. We've – the way that the fund currently runs – and, of course, open to talking about any improvements, but the way the fund currently has been – well, previously ran is we have a research advisory committee which is
40 made up of, you know, significant researchers in the space, and that research advisory committee, on consultation with the sector, works out a set of priorities for the fund, and also in consultation with government, and so that - and that then determines the, kind of, overall research agenda.

45 MR STONE: You're keen to talk more about - in your submission, you talk about AOD not being a separate - where we've asked for information requests around AOD – Alcohol and Other Drugs. Sorry. And in the Alcohol and Other Drugs space,

we've posed the question about them being a separate schedule. Your submission is saying it should just be reflected in the body of the agreement and in the suicide prevention schedule. Keen to hear more about why.

5 MR STONE: Look, that has come from us actually talking to the AOD sector – our friends in the AOD sector. There are some concerns that – especially given some of the lack of governance arrangements that the – in the AOD sector that a schedule under this might be seen as the governance arrangement, and that sector is quite clear that they actually have a whole bunch of ideas, which I will let them talk to, about
10 governance arrangements that need to be in place cross-jurisdictionally, and so there is a concern that a separate schedule would be seen as filling that place which it would not and could not do and so it would be much better to have AOD reflected in the body of the agreement.

15 From our point of view, this is really important. Obviously, the harms of alcohol and other drug use is a significant driver of suicide risk. You know, we do want to see our sector as skilled as possible at dealing with that circumstance when they encounter it, and so it is really important to have AOD reflected in the suicide prevention schedule. We strongly support that, but I think it would be better to have
20 it reflected in the schedule rather than to be a separate schedule itself.

MR BUTTON: Okay. And I was going to come back to that because I didn't actually ask that at the beginning – is whether or not Suicide Prevention Australia – your reaction to us recommending a separate schedule within the agreement that
25 focuses on those things. Yes, there are overlapping pieces, but certainly from the conversations we've had with yourself and others in the sector, there are some unique components that we think best to fit in a separate schedule.

30 MR STONE: Yes.

MR BUTTON: I should have started by asking that one, to get your reaction on it first.

35 MR STONE: No. No. That's – and you're right. It's obviously – it's something – it's the first thing that we went to our members about – was talking about that, and as I say, it has been responded to quite positively by the people we've been talking to in the sector. The idea of a separate suicide prevention schedule seems to make sense to most people.

40 MR BUTTON: The other thing that you mention in the submission is in relation to – you talk about transparency of funding, but then also, I guess, the focus on transparency of outcomes and data and a data dashboard. You mention some of that in your submission. I guess - can you talk a little bit more about that.

45 MR STONE: Yes, look, absolutely. And there's really a lot to say on data. The current national agreement had relatively, I think, ambitious – an ambitious strategy, in terms around – or strong ambitions on what sort of data reporting it wanted. I'm

not sure that the resources allocated to that really matched up to that ambition. There's an awful lot of indicators in the data plan that are still yet to be developed. Here we are, very near the end of the agreement. So I do think that there's – there's potentially a lot more work that could have been done and could be done in the next
5 agreement in terms of data reporting. From my point of view, particularly in terms of monitoring the suicide prevention sector, it faces an inherent challenge, as any prevention sector does, which is that you're trying to measure what didn't happen and that's inherently problematic. And so there are difficulties in monitoring, but those difficulties are able to be overcome with a sufficiently comprehensive and
10 nuanced monitoring system.

The best way to do it is to be measuring right along the track from resources put in, activities undertaken, outputs generated and outcomes. If you're actually measuring the whole thing, then you can get some idea because, obviously, you want –
15 outcomes are obviously the thing, ultimately, that you want to see change. You want to see there being less deaths by suicide. You want to see there being less attempts. You want to see there being less distress. But those are impacted by a whole bunch of factors that are outside of the control of government or the community centre. But if we can see what the government – what government and the community sector are
20 doing, then we can relate that to any changes or not and get a good picture of whether or not we are actually being effective. And so it really is about making sure that the whole of the monitoring is done, all of those different kind of pieces along the journey.

25 DR JACKSON: And are there any examples where that is occurring or are we just – no.

MR STONE: I think there are. There – no. No. There are very good examples, and I think, in many ways, the data monitoring space here, we've seen some
30 significant improvements. What we have seen is, at least in development, obviously, we've got the NSPO working on the outcomes framework. They're consulting on that, with a range of people in the sector, including ourselves. That outcomes framework is looking very good and will be an important piece of the puzzle. As well as that, we have seen the suicide and self-harm monitoring team within AIHW
35 do some incredible work around kind of activities and some of the outcomes as well.

And so there is – there has definitely been a lot of work done. And as I say, the data governance forum within the current national agreement has also, you know, brought together an incredible group of different data experts across the jurisdictions, and
40 they've done a lot of good work. It's more about further resourcing those systems to make sure that we actually have all of the numbers that we would like to have to see what's going on.

DR JACKSON: I think you also mentioned the peer workforce and a view that we
45 need to strengthen that recommendation. Did you want to talk more about that as well?

MR STONE: Yes. Absolutely. So and look, obviously, there are lived experience led organisations within our sector who can speak more comprehensively to this point than I can. But certainly, what we've heard from them is often about the difficulties in the lived experience space. One of the things I should make clear is
5 that there is a difference, obviously, between the peer workforce and then the lived experience workforce, which incorporates the peer workforce, and both the non-peer lived experience work force and the peer workforce are important. And for both of those workforces, there are often difficulties in terms of things like career progression, things like sufficiently targeted training being available.

10 So there are a range of challenges that are faced in that space. And you know, we would like to see more efforts devoted to, say, for example, more specific training being available for suicide prevention lived experience as opposed to just lived experience in general, which often defaults to simply being mental health lived
15 experience. That's not, by the way, to denigrate in any way the importance of the mental health lived experience training. It is, of course, incredibly important both for the mental health space and to the suicide prevention space. But there are many people in the lived experience space who do not have a mental illness, and so a great deal of that kind of mental illness, mental health lived experience training is not
20 relevant to their experience, and we need better resourcing of specific suicide prevention training. That's one example of the sorts of things that could be done in a workforce initiative to further bolster the suicide prevention workforce.

MR BUTTON: And again, I'm going to ask a sequencing question on this one,
25 Chris. What we've – as you would see in the interim report and we've talked about before, we're talking about saying – is going down the path of a need for a scope of practice, so at least we get a better understanding of the role and how the role interacts with others, including clinicians that are working in the space. Does the scope of practice come first or does the tailored training come first?

30 MR STONE: I think that it is – in terms of sequencing, it probably does need to be things running in parallel rather than waiting. As I say, what we're hearing from the sector is level of in-patients around this – there's a strong feeling that we do know a number of really critical things that we can do. Obviously, we don't know
35 everything, and there's still a need for planning and strategizing. But there are number of things that we know need to be done now, and there's no point holding that off while we explore further all of the details of what we need to do, which is why, as I say, we're advocating for an initiative rather than a strategy. We would like to see something that comes – that hits the ground with the series of actions that
40 we know need to be taken as well as, of course, incorporating, planning for what we need to do long-term to strengthen the sector.

MR BUTTON: Going back to the transparency and outcomes piece, the dashboard, as we talked about before. We're talking about what's the publicly available
45 dashboard look like, who should host it? You've posed some thoughts as well around that being with the Mental Health Commission and the Suicide Prevention Office. Tell us – I guess, talk to us a bit more about that.

MR STONE: Yes. Absolutely. And so we specifically took this to a number of members to ask about where they felt it fitted best, and certainly, what we heard strongly was that the National Mental Health Commission and the NSPO are the right bodies to be doing this work. There was a good deal of discussion both about
5 the pragmatics of it, in terms of where would it get the most attention, which is obviously important from an advocacy point of view, but in terms of making sure that it aligns with existing work, that's what was regarded as the kind of key important factor. And so you do already have – obviously, the Mental Health Commission does quite a bit of this work already. The NSPO does quite a bit of this
10 already and, indeed, is developing an outcomes framework in consultation with the sector. So it seems logical to place it within those organisations.

MR BUTTON: I'm assuming you would see the outcomes framework forming the basis of what public reporting might look like.

15 MR STONE: Look, absolutely. For the suicide prevention schedule, the outcomes framework should obviously guide it to a significant degree.

MR BUTTON: Okay. Good.

20 DR JACKSON: That's really useful.

MR STONE: And look, you know, something else that I kind of – I guess, I should add on that point is about the resourcing and the structure of those bodies.
25 Obviously, the National Mental Health Commission and NSPO are under review at the moment. It's still not entirely clear what the outcomes will be in terms of the level of independence that they will get at the end of that process. We're advocating strongly, and we are very hopeful that the government will determine that they should be independent bodies – significantly independent bodies sitting outside, kind
30 of, the Health Department and having, hopefully, significant powers to require information from government in order to make sure that they can effectively fulfill this monitoring role. And so those sorts of powers are important. If those bodies are going to be – have this responsibility, they're going to need that ability to get the data and going to need to be set up with sufficient independence that they can put that
35 data out there publicly without fear.

MR BUTTON: And in the absence of the Mental Health Commission getting to – being an independent statutory entity again, what would that look like, Chris?

40 MR STONE: That's very – it's very difficult to say. I think – well, what I hear from the members is that they're strongly pinning their hopes on the government actually making those bodies – giving those bodies a level of independence so it can fulfil that role. And I guess, all of this, it kind of – it's predicated on that assumption, and I – like, it would not be an ideal situation to not have that set up.
45 Another thing, by the way, I should mention is, of course, resources. Both bodies are not large, and so we need to make sure that they're adequately resourced to do this task as well.

MR BUTTON: Yes. And the other segue in that space, I guess, is then do you think and your members think it may be a role also for state and territory mental health commissions in similar reporting or similar transparency approach to reporting and outcomes, etcetera, as well?

5

MR STONE: Look, that would seem most logical. Obviously, if – the situation varies quite a bit from jurisdiction to jurisdiction. Not all jurisdictions have a mental health commission, and so there are – it would be – in many cases, the mental health commission would be a logical body to kind of coordinate with the national mental health commission, and – but – and in the jurisdictions where that isn't – where that doesn't exist, there would need to be some other body found in order to kind of help do that work.

10
DR JACKSON: We've got five more minutes. Did you have anything else you wanted to raise in particular or anything else you wanted to emphasise? We did like the maintaining draft recommendation– you know, that you liked a lot of what we had said. If there's anything you'd like to elaborate on further, I guess now is your opportunity you think is critical in terms of those recommendations.

15
20 MR STONE: And, look, I think it's all fairly clearly set out in our submission. Yes, absolutely, we – what we heard strongly from the sector is that the Productivity Commission has very effectively determined what the current situation is. The findings were absolutely spot on, and so many of the recommendations we just completely agreed with. There were – obviously we have set out some ways that we
25 feel that some of those recommendations could be strengthened. One of the things that we have mentioned is, of course, the need for the national suicide prevention strategy to be kind of embedded in the schedule in a really clear way.

30 The interim report talks about making sure that the suicide prevention schedule is kind of aligned with the long-term objectives of the national strategy, but, in actual fact, the national strategy contains a number of things that could be put in place right now. It has actually a number of short-term actions as well as long-term actions, and so what we would like to – so we – although it is a 10-year strategy, much of that could be achieved within the lifetime of the next agreement, and so we would like to
35 see those actions that are more short-term be embedded in the suicide prevention schedule of the agreement so that it governs it more strongly. That's, I think, an important point.

40 MR BUTTON: Yes. No, and it makes sense that you take those things out of the broader, long-term process that's been undertaken by the suicide prevention office to then say, "Here are the things that we realistically need to prioritise and do in the next five years," and that becomes the schedule.

45 MR STONE: Exactly. Yes, that's what we would see as the ideal situation.

MR BUTTON: That's been really helpful, Chris.

MR STONE: No problems. Thank you.

MR BUTTON: We appreciate your time. Thanks very much for participating, and I'm sure we'll see you again soon.

5

MR STONE: Yes. Always happy to help any time.

MR BUTTON: Thank you.

10 MR STONE: See you later.

DR JACKSON: So now we have Kerry Hawkins and Cathy O'Toole from Community Mental Health Australia, who are on – we're a little bit early. Look at that.

15

DR JACKSON: Hello.

MS O'TOOLE: Hi.

20 MR BUTTON: Here, so that's great. Kerry's there as well?

MS HAWKINS: Yes, hello. Hi. How are you?

MS O'TOOLE: Sorry for the confusion.

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DR JACKSON: That's okay. It's – we're getting there. We're managing the technology. I think we're doing relatively well all around. We haven't put ourselves on mute all day. It's kind of, you know – shouldn't have said that, obviously. Well, thank you very much for joining us. If we could just start with an introduction with you introducing yourselves, just for the transcript, and then we have time for you to provide an opening statement and then we can sort of delve deeper into some questions around your submission and your statement.

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MS O'TOOLE: Thank you. I am Cathy O'Toole. I am the president of Community Mental Health Australia, and I live in Townsville, Queensland.

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MS HAWKINS: And I'm Kerry Hawkins, the CEO of Community Mental Health Australia, and I'm based on Whadjuk Noongar boodjar. Do you want us to just dive straight into our opening statement?

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DR JACKSON: It's a little bit formal, but thank you.

MS HAWKINS: Yes. Will do. Gosh, this is bringing back traumatic memories of the original original Productivity Commission hearings, and that will probably go on the transcript, so I'll just hold it there.

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MR BUTTON: We'll make sure Stephen reads that, too.

MS HAWKINS: I – yes, yes. I know. But he was delightful. So our opening statement – I think we'll just keep it fairly high level, and we did send through our –

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the three key points we want to talk to, but we did want to say that we were delighted with the initial interim review report. We agreed with much of the recommendations, the framing of the recommendations, and obviously we're choosing to focus on three areas that are relevant to our sector, but, of course, we're very, very supportive of the report.

The other thing that we just wanted to note was we felt as though this report – the context into which it landed is critical. This is not a historically neutral moment in time. This is a review of an agreement that follows on from multiple structural, both federal and state, attempts to enact mental health reform, failed attempts. And so the key thrust behind our recommendations today are really around how we can prevent this from happening again and to provide our understandings around what that might mean and what might need to happen. And so we absolutely agree with you around the lived experience governance, around theory of change approaches.

We didn't think that you went hard enough and strong enough around system transformation in particular. I did go back and look at the Closing the Gap review, which had caught my eye when it first came out as well because much of the language and much of the framing in that I think reflects the consciousness-raising space that I think we still find ourselves in in mental health, which is still very clinically, bioindividualistically dominated, and we haven't yet got to a conversation around what a psychosocial approach might look like and how we might transition across to that, which is really where people with lived experience want it to be, and where internationally a lot of the thinking and innovation is going.

And so with that framing, I just wanted to run through our thinking on psychosocial supports and also note that as a community – as a peak of the national community

mental health support peaks, we're not funded to do this work, and so very, very conscious that our submission is – it reflects the lack of resourcing that we have. We don't have the resources to go out and do the research and to provide you with the data we'd like to provide you with, so in some ways it's very much an opinion-based piece. So bear with us through that.

So the first piece we wanted to talk to was just to elevate as far as we can an understanding of the work that needs to happen to build that consciousness and that literacy around what constitutes psychosocial supports, and we feel as though we'd like to see a much more focused space around the national service planning framework tool, what we can do to review that, because it's a highly clinical service planning framework tool that still defines how services are delivered, and of course the agreement work around psychosocial supports and unmet needs is very much framed by that and is a very limited piece of work.

We think the other area that could be strengthened is the commissioning capabilities for PHNs and LHDs, and so I looked at the paper – I think, Angela, you authored it – on the care economy and the pillar that's feeding into the work that's going on in the broader space at the moment where you identify LHNs, LHDs, whatever they're called, in various states and territories, PHNs, and then ACCHOs is the commissioning bodies. And that doesn't reflect to us any structural capability to commission psychosocial supports. We know that both LHDs and PHNs are profoundly clinical, and so we believe there needs to be a lot more capacity-building work done into those commissioning bodies to enable them to commission psychosocial supports. And obviously, having greater lived experience leadership - and we speak closely and often with the lived experience peaks. We're aware of the conversation they had with you today and the work that they'd be asking for in that space, and so of course we support that as well.

I think some of the other things are looking at the opportunities. So when you did the first round on this review, the machinery of government hadn't clicked into place - it's still working its way through the system - but we'd be very interested in the opportunities that some of those structural and cultural barriers that this new alignment between disability policy and health may present in terms of psychosocial supports as well, so very, very interested in what that might look like.

We know it could potentially delay things. We were supportive of the delays that you'd recommended for exactly those reasons to start to build the - what we would call cultural capacity around redefining approaches to distress that are non-clinical to start to work through the system. I won't talk too much. I am conscious of time. So Cathy, I might throw to you just to talk about some of thinking we have around - - -

MS O'TOOLE: Yes.

MS HAWKINS: - - - the workforce.

MS O'TOOLE: Thank you, Kerry. And I will just acknowledge that I sit on the Wulgurukaba land in Townsville. Workforce is critical. The psychosocial supports are delivered by the psychosocial component of the workforce. There's a lot of work to be done in that space. We don't have any real data available on the psychosocial community mental health supports workforce, which is, you know, somewhat challenging.

We need to address urgently the workforce shortages. This is - even taking into account without looking at the unmet need and the psychosocial supports, we still have a workforce shortage. It is still problematic. We need to - we understand and know, because we're part of it, that this is being progressed through the psychosocial project group, and they will create some strategies in that space.

The unfortunate part about the workforce was our sector was omitted from the research that was done into the National Mental Health Workforce Strategy. That was an unfortunate error we believe happened. So it's very urgent that we can achieve an onramp to meet this up and coming investment, and CMHA continues to press government for this critical work.

In the period up to the negotiation of the successor agreement, remedial policy work is required. We have to develop a psychosocial supports workforce strategy to address the unmet needs to get the psychosocial supports uplift either as part of the National Mental Health Workforce or alongside it, but it's absolutely critical it happens.

An update of the National Mental Health Strategy to include the workforce and an immediate uplift in the workforce to prepare for an investment into psychosocial supports. The community-managed mental health sector faces critical workforce shortages, as I have mentioned, and it grows every day. Particularly, I can see this living in a regional community, and I have also had experience working across the rural and remote areas. It's really critical.

It's worsened by short-term contracts and funding uncertainty to deliver that person-led, lived-experience-led. We need long-term sustainable funding that enables job security for the sector to grow. This is particularly important. If we look at our workforce, it's probably an aging workforce, and we need to be looking at what are the succession plans, and young people are struggling enough to get into the housing market without the fact that they haven't got secure work.

Investment in lived experience and psychosocial workforces, including training - accredited training is really important, and microcredentialing is really helpful, and we also need those really clear career pathways so people entering in don't see it as a fill-in job "until I find something". These challenges will be further compounded if expectations around improved data collection, evaluation and monitoring are increased without investment in the workforce capacity.

And we are very aware in our sector that we provide a lot of the employment for people with lived experience coming into the sector, and our sector is very conscious that workforce development is essential and critical, particularly if we're going to talk about rights-based supports, then that education has to come into workforce development. Thank you. And I'll hand back to Kerry.

MS HAWKINS: Thanks, Cathy. I think just the final point we wanted to make was around greater attention to system transformation, and I completely appreciate that everybody has a different understanding of what that might mean, but what we are being informed by is really an understanding of the UNCRPD and what that might mean in terms of a system that has been dominated until now by the discourse of service providers.

So we've worked closely and intentionally with the three lived experience peaks, so the National Consumer Alliance, Mental Health Carers Australia and the Indigenous Australian Lived Experienced Centre, Auntie Vicki, a Yawuru woman, up in Broome, to start to talk about what a system might look like that is informed by human rights, puts human rights first, that is absolutely community-based as opposed to community-supports-based and what that architecture might look like and what it might look like to model a system where the service providers work in partnerships with and are guided by people with lived experience, and we've been exploring, actually, the distinction between the population modelling of clinical understandings of people's understandings of distress as opposed to the express need of community members, which is a very different proposition.

We've been running a project - it's out of the ILC program, so it's inherently flawed, but we've been trying to use it to get some research around what happens when you ask people what it is they need in reality on the ground, and it's always around social determinants. It's always around housing, jobs, relationships. So what might a service system look like that supported people to address their real needs.

And we think that that obviously is a very - the scale and scope of that kind of transformation: we'd be looking for more enablers moving forward to resource - and you absolutely talked to this in your interim review report. To resource lived experience, to drive this work. But partnership work and the relational work that that takes is significant, and we would just love to see more focus placed on what might be some of those - whether it's a programmatic thing. We look at something like the ILC, which is about capacity building.

We didn't see a lot in the interim review report around capacity building of government systems, particularly health systems, to transition away from what is effectively a coercive medicolegal system, where human rights are breached by design, towards something that is far more community-based, citizenship-based, and that kind of shift - and we know that that's mostly at state level, so how can we - what are the levers we can use to drive some of that transformation?

And whether that means innovation funding, whether it's just something that you discuss with lived experience peaks, but we'd be really keen to see some more language in there around addressing that entrenched bio-individualism, the endemic human rights breaches that occur in this system at the moment, the lack of attention
5 placed on social, economic and cultural rights for people that come about through relational rights-based supports.

So very interested in how we might be able to craft up something a little bit more contemporary as well to drive a little bit more reform and move us away from this
10 culture that we have at the moment of what's pretty clinical. That's really it. Happy to have some conversation about it.

MR BUTTON: Thank you.

15 DR JACKSON: Thank you.

MR BUTTON: And that's been - - -

DR JACKSON: Given us a lot to think about.
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MR BUTTON: - - - really helpful. Very, very detailed. And that's good. It is good. I'm going to go back to your first point, Kerry. We talked about the review of the service planning framework, which is an important part, because, as you would have seen, I guess, in the language that we're using in the report, it's critical that the
25 mental health services planning framework is consistently used, because at the moment - and I guess this comes to your point around capability.

At the moment, we've seen - what we are seeing is that where it's used well and where it's used as a tool between both the PHN as well as the local hospital network,
30 or the HHS, in Queensland's case, those things are working effectively and you can actually see there's some things that are working in tandem to getting services, services occurring and providing community support. Where there's limited capability and it's sporadic use, then we're seeing the fragmentation. So interested to know - where we're going is down the capability path, that there needs to be greater
35 investment in the capability for the application of the framework, but you're suggesting a review of the framework itself.

MS HAWKINS: Yes.

40 MR BUTTON: Can you talk to us about that.

MS HAWKINS: Yes. Yes. And even in the original Productivity Commission review, that was very much, I think, the understanding by service providers that everything existed in that - in the modelling that was there. It was just that it wasn't
45 being effectively used. So for example, there was always, in the existing framework tool, supports for families, as an example. Never probably effectively funded. Community supports, you know, sit at six per cent. It probably should be up around

20 per cent, something like that. I think there two comments I would make around that. One is that it's still a clinically framed tool. And when you say things are working effectively, I would like to hear that from people with lived experience, and I would like it to be mapped against full citizenship attainment and outcomes that demonstrate that they've got real homes, real relationships, real jobs.

So often, when we hear things are effective, it's from a service provider perspective. And when we – so I was on the original project working group having a look at the HPA report, and we refused to endorse it. So people with lived experience, Rachel Fishlock, Vicki McKenna from – so Rachel from Gayaa Dhuwi..... Vicki from the lived experience centre, Marsat from Torres Strait Islander lived experienced centre component all refused to endorse it because it didn't start from a place of actually what are people's needs, what are their real needs. And so if you frame it against social and emotional wellbeing, if you frame it against understandings of distress that are trauma informed, that are around recovering citizenship, not some broken brain concept – it's a profoundly flawed structurally – tool because you're always starting with an assumption that people need this many psychiatrists, this many psychologists.

And the people that model these systems and deliver these services are all acculturated in that way of thinking. So that's why I don't think – that's why I talked a little bit at the end about system transformation because we've kind of absorbed a way of understanding this tool. I think that it's how it should be. And we would be suggesting, well, if you actually start with what people need and meet those express needs, it's probably a different proposition.

MR BUTTON: Okay. No. That makes sense. And I will let you go Cathy because I wanted to come back to that purely because it's the first time we've heard that in this process, is to focus on fixing the tool and fixing the framework as opposed to how do we to use the framework better to improve services.

MS O'TOOLE: If I could just say, I think it depends, from your point, on where you live. So for example, I ran services on Palm Island. I would have to say no. It's not effective in that HHS. So I think we need to be mindful of that too. The demographic plays a big role in how effective – you know, regardless of whether it's a clinical or community based, where you live and what's available is really, really important. And often, what meets the metropolitan area does not have any bearing on how it is when you live in regional, rural and remote. To Kerry's point, the people that you talk to – and I talk to people up here that I know who are in the system, they're not having the experience of it's working, and one of the biggest complaints people have in the community where I am is it's a broad community.

So it's a refugee settlement city. It's around about, "I haven't got anywhere to live. I haven't got a job. I can't make ends meet." Belonging and engagement are not there, so people feel very isolated. And the elderly population, we don't tend to talk about that much in the mental health space. It's terrible. People are very isolated.

So I think, to Kerry's point of reviewing the tool itself, from that I'm the user perspective, would be a wonderful thing to do.

5 MS HAWKINS: I don't know if you've spoken to David McGrath at all, but we've had this conversation before as well, and he has a drug and alcohol background. And so again, from that perspective of co-occurring issues, it's not fit for purpose, and he's aware of other tools that he believes are more fit for purpose, more aligned with recovering citizenship again. So I know it's a big jump, and I'm not saying do it straight away, and it may well be an interim solution is just to make it more
10 consistently contemporary in its application. But I think also we have to be – in the same way we made the shift around moving from clinical to social and emotional wellbeing, I think there is a lived experience movement if you listen deeply and closely that would be saying, "Actually, this is not – clinical understandings of distress are not necessarily our understandings of distress, and we need a tool that
15 reflects that."

DR JACKSON: Yes.

20 MR BUTTON: Yes. No. Again, it does make sense. So it's not necessarily something that you're throwing out because you want to focus on the consistent application of the use of the tool and build around that until it's actually going to get a better outcome.

25 MS HAWKINS: Yes.

MR BUTTON: And so if that is something that's – certainly, required, then it's definitely part of the consideration to say, "How do we make sure the tool that people are using to then form what services are being commissioned do consider, I guess, people's needs?" And if, at the moment, you're suggesting it doesn't, then –
30 okay. Well, we need to make sure that those things are part of the process.

MS HAWKINS: And I think – thank you for pulling that part out as well. I think it's a bit of a sacred cow, but there's a fair bit of international evidence now that clinical front-line treatments aren't necessarily as effective as they're claimed to be.
35 If I was to ask for the research evidence that informs that model and informs outcomes of those two front line treatments, I don't think we would see a lot of evidence there, frankly. I mean, I would be interested in seeing it. So we may well be commissioning services at the moment that we make assumptions about the efficacy that may not actually be there as well. So it's just a cautionary thought that I
40 have.

MR BUTTON: No. No. I appreciate it.

45 DR JACKSON: No. I think there are – yes. I mean, it's something to be conscious of in terms of, you know, what the status quo biases evidence, you know yes.

MS HAWKINS: Yes.

DR JACKSON: The cultural piece that you mention, there is obviously a stigma strategy that was meant to be developed as part of the current agreement that's yet to be released. What role do you see that playing both I guess, in the broader community but also this transformation of – I'm almost seeing it like I won't get too technical, but in the – you know, transforming the way government does business, if you like.

MS HAWKINS: Yes. Yes. I mean, it's so interesting. That piece – that strategy came out of the fifth national plan, and it was an aggregation of quite a few items, and then kind of got rolled up to a strategy that, of course, never got released. So I was really glad that you picked that up. I just want to know, out of that fifth plan as well, there was another stigma busting piece that was a separate action item which was around the rollout of the World Health Organisation's quality rights training. So it was for Commonwealth and state health departments, all staff, to be trained – it's free. World Health Organisation – in human rights, effectively, and that was intended to be – that's the lever internationally that they're using to try and shift some of these cultural issues.

So that was never completed, that piece of work. Western Australia is an example. It just said, "It's not aligned with our legislation, so we can't roll it out." Other states just said, "We will roll it into something else." And so this – to your question around stigma, it's part of a broader cultural issue where there is resistance within government systems, clinical staff to be re-understanding distress and understanding people's rights because they have a very solid belief in the way that they've been trained. And so I understand the criticisms around the strategy, that it was never really a strategy in that sense. It's a wish list of actions in various domains.

But I do see it as a critical lever in terms of that cultural transformation that we need to take. And I see, you know, you've struggled with it again – when I say "you" – sorry. The - - -

DR JACKSON: Yes.

MS HAWKINS: The Productivity Commission with the Closing the Gap review as well. It's persistent. But I think we need to start naming it, that actually we know that clinical services can be the most stigmatising experience for people. The conceptualisation of people as walking individual human – you know, units of deficit is stigmatising. The actual conceptualisation as individualised pathology is stigmatising. And so for me, it's quite an important lever. I just think we have to be quite careful about how it gets rolled out because we know the backlash is problematic, but we do need to start naming some of these experiences of stigma that people report every day, and their families.

MS O'TOOLE: If I could just add to that. The language of psychosocial is very stigmatising, if you think about it. It really is. So maybe we could do some work there. And just on the stigma strategies, I was – went to a meeting – it was either – it was before the 2013 election. It was very early on in Mark Butler, being our first

mental health minister, to try and get a stigma reduction strategy up and running with CMHA. So we've been trying for a long time, and just to add to what Kerry says around the trauma, language is so important in this space, the way we use language. My bug bear, as I said, is psychosocial. It's not the best language. We could think
5 of something better surely, and I'm aware it's in legislation, so that requires some work, but I would love to see some change in that space, so people feel more comfortable in seeking support.

10 MS HAWKINS: Absolutely. I was just – I was interested as well, Angela – your question – are you looking at, like, how can it be deployed? Because I – you know, I saw Kevin Bell's submission, all of the people, you know, involved with lived experience in that project, and hammering for it to be released. Are you trying to understand what the best way is to use that particular document to address the experience of discrimination in services?

15 DR JACKSON: I think it's just for us to have more on the record around and you understand, like, part of the process is around why it's important and what role it would play. Like, it's a – I think, in essence, yes, it's in the current agreement and it's there, and so it should be done but, actually, what is its purpose? I just want to
20 change it sorry, not - just to get the information clear for us to then think about how we incorporate in terms of that recommendation, and - - -

MS O'TOOLE: Yes.

25 DR JACKSON: not to say, you know, it's just a strategy, or whatever.

MS O'TOOLE: Yes, yes.

30 DR JACKSON: the reason, you know, we wanted this strategy for X, Y, Z and what it's intended to do, and why it's important in terms of - - -

MS O'TOOLE: Yes.

35 DR JACKSON: - - - addressing the outcomes - objectives of the agreement, because of these reasons. That's really what I was after.

MS HAWKINS: Yes, yes, and for me some of the framing, you know, in that Closing the Gap thing, when there's priority reform area three and we talk about institutionalised racism. Well, in our systems in mental health, we've got
40 institutionalised biomedicalism, and discrimination, and whether it's the experience in services of coercive treatment, for example, whether it's just the absence of those life affirming psychosocial supports to give people social, economic and cultural rights being met, it sits within that broader discrimination piece, I think, that government are actively enacting through the way that they currently provide
45 supports to people. It's not so much stigma. I think most people with lived experience would rather refer to it as discrimination. They feel discriminated against, and that that's the area that I think we should be focusing on.

MR BUTTON: It certainly builds on – because what we found through the – what we’ve put into the interim report, that then focuses on what needs to happen next, I guess, Kerry, because what we’ve obviously identified as well is that there’s already a mental health workforce strategy, but the mental health workforce strategy is a whole range of unfunded initiatives. So there’s no money that’s attached to initiatives that sit in this strategy to then roll out. So, in essence, when you think about the stigma strategy, it’s saying, okay, well, it’s great to have a strategy, it’s – get it – we need to make sure it gets released, because it will have an impact, but there’s also the need to think about funding initiatives that sit within the strategy to build the capability of the workforce to understand what it means.

MS HAWKINS: Yes, and I think that probably goes to the commentary for us around system transformation. So as you’ve observed, in the original agreement, not much was funded. I would love to see more funding attributed to this – whether we call it capability-building work to address discrimination, to ensure co-production, to see that transformation of the system. I would love to see that work funded. We had the experience in Western Australia where there was a 10-year bipartisan plan to rebalance the system towards community supports. It was never funded. We kind of chased it through all of the parliamentary committees, and it, of course, petered out into nothing. So I would love to see some discrete pieces of work that actually attack transformation itself, and capability-building for people to engage in system reform in a space that’s very difficult for people to – particularly clinicians who have been trained to help people, understanding that they’re harming people.

MR BUTTON: Okay. I’m conscious of time, and - - -

MS HAWKINS: Yes.

MR BUTTON: - - - I want to make sure that if there’s any other things that you both feel the need to make sure is on the agenda, or put on public record today as part of your submission process, I want to give you that opportunity before we cut you off and say goodbye for the day, but I want to make sure at least there’s – you – we’re giving you the opportunity to do that.

MS O'TOOLE: For me, I think we’ve touched the key areas, and thank you very much for the opportunity, I must say, but I don’t have any other things to say. Kerry, you may.

MS HAWKINS: No, nothing to add. I think we’ve put it in our papers. We would like to pay close attention to the psychosocial supports working group that’s working its way through the system. I think if there is a pause, we would love to be more involved in that. I think it has been a bunch of bureaucrats, no disrespect intended. I was one, but there has been very little lived experience expertise, or sector expertise, as part of that work, and we would be really keen to shape – to partner with lived experience to shape that work moving forward. And other than that, thank you. Yes, I appreciate it’s very late in the day and you’ve had far more on your plate than we have.

MR BUTTON: Really appreciate your time and your - - -

MS O'TOOLE: Thank you.

5 MR BUTTON: - - - presentations today. It has been great to hear from you.

MS O'TOOLE: Thank you.

10 MS HAWKINS: Thank you, and you.

MS O'TOOLE: Thank you.

15 DR JACKSON: We will now move on to Danny Rock from the WA Primary Health Alliance.

MR BUTTON: Now we will move to the last one for the day, which is Danny Rock. Thanks for joining us this afternoon, Danny.

MR BUTTON: Thanks for joining us this afternoon.

DR ROCK: You're welcome.

5 MR BUTTON: I wanted to give you the half hour of time to then talk through some of the stuff that we've talked about previously on our first catch-up.

DR ROCK: Yes.

10 MR BUTTON: other things post the interim report process that you want to focus on in your presentation today, and certainly we can ask some questions from there. Angela Jackson is with me.

DR ROCK: Okay.

15 MR BUTTON: - - - start by – start with your – for the transcript– state your name, title, etcetera - - -

DR ROCK: Yes.

20 MR BUTTON: - - - and then we can go from – you can go with an opening statement and go from there.

DR ROCK: Yes, I got – I prepared an opening statement, so I – perhaps I will go
25 with that. So, yes, my name is Danny Rock. I am the principal adviser and research director at WA Primary Health Alliance. WA Primary Health Alliance operates all three of the PHNs in Western Australia, and I guess that's a good place to start my preface by saying, you know, what I'm going to talk about is complementary to the recommendations made in the PHN Cooperative submission, which we endorse. So
30 today – and my focus today is on – particularly on inequalities generated in the way we plan, what we measure and the choices about the treatments and interventions we fund.

35 So WAPHA, like others, I'm sure you're aware, operate within a complex web of decision-making processes that underpin planning commissioning, performance measurement of the publicly funded treatment systems, and these have evolved over

time. They're well-established, they're overseen by highly capable public servants, and they have considerable benefits. They work – you know, they work well, but what works for – on average, doesn't necessarily work for all, because embedded in these systems are some silent passengers, you know, biases like viruses that

5 propagate within the host itself, and this is the unintended consequence of the design of the decision systems, and I think I've said in previous occasions, these are features and not faults. I mean we like to sometimes call them faults when they produce things we don't like, but when they generate the things we like, we see them as features and we like to get the credit for that, but when they don't produce the things

10 we don't like, well, we say that's a fault of the system, and they – these biases remain largely invisible to individual decision-makers, yet they can produce systematic and disproportionate harms to groups whose needs and capacity to benefit are compromised, and, like I said, they're guided by good intentions, you know, I mean, these processes, but they remain vulnerable to perpetuating hidden harms, and

15 that's because this fundamental precept, which is the purpose of a system is what it does, not what is intended, and I think seeing things from that perspective of what the system does is actually quite instructive, because it recognises that the decision systems that we operate are a fabrication, you know, they are organised human processes and human arrangements and policy choices, and the features reveal the

20 system preferences and its implicit priorities, not merely its intentions, and, once this has surfaced, they can be systematically reformed using the same apparatus that sustained them. You know, it's not saying you need to pull it down and start again, and, in this way, the mechanisms that produced these disproportionate poor outcomes for some appropriately called underserved groups are also the levers through which

25 the corrective reforms can be enacted, at least from WAPHA's perspective.

And with this in mind, there's a disconnect, then, between, like, the wording of the agreement and the NHRA as well to build – fund publicly funded mental health systems that are resilient, and then the planning and implementation mechanisms that

30 are the means to bring this state progressively into being, you know. And the most – I think – we think the most effective way to inoculate a decision system against these pernicious effects is to imbed diversity in decision-making, fundamentally, so that's a point; this means structurally incorporating the voices of those closest to the realities of care delivery and system navigation, because they represent the places

35 where all of the value we seek is created or lost. I mean, WAPHA doesn't generate value. We create systems that we hope that contribute to value, but we don't generate any value at all, we're just a cost, as is everything else except the places where the care goes.

40 And we would argue that the people with lived and living experience and GPs through their representative bodies are the people who do this. They're expertise really is foundational to improving primary care through the auspices of agreement, as well as others, you know, Aboriginal and Torres Strait Islander health professionals, clearly, allied health workers, NGOs and sector peaks. So what I

45 would like to focus on and hopefully go through in detail are matters related to knowledge, information and data infrastructural systems that underpin health planning decision-making, and I kind of connect this always together in three pillars.

You know, the first pillar is what works; the second one is, you know, what is the current state? You know, what is going on; and the third is, you know, what is realistically achievable as a future state? We can imagine lots of things, but, you know, what falls within the realms of reality?

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So what works? So there is an absence of detailed national guidance for regional planning and commissioning under the agreement, but that kind of highlights, I think, a broader systemic issue: the gap between the policy intent and the realities of implementation. The department has developed a set of principles, which are good, to support regional planning for PHNs; they're helpful, but they're not practically useful on their own. I mean, but they're necessary, and I think to translate principles into practice, we see value in developing a national service planning standards. Standards are great for interoperability, and the world is held together by standards, and, in this way, framing planning and commissioning decisions are system-level interventions; they are really like clinical care, they have the potential to create both benefit and harm, and we should treat them accordingly. We should treat them as if they are a therapeutic endeavour, because if they're not a therapeutic endeavour, why do we bother with them at all? Because are they neutral to outcomes? If they're not, we should treat them as such.

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And I think one way of thinking about this is giving consideration to their development as a formal supplement to the Australian Commission of Safety and Quality in Healthcare, national standards – there's some for, you know, health systems and there's some for primary care – and linking it and framing it within the Australian Charter of Healthcare Rights, and there's some absences there, there's no, really, rights around digital care, but I think there's sufficient there to that

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Next, I think there's a need for intervention and treatment guidance relevant to and reflects the context and the circumstances of specific underserved populations. For the same principle: what worked for the average doesn't work for everyone. And establishing a central, accessible repository of synthesised evidence would support regional planners, really, and policy makers to make decisions that are consistent, equitable, and aligned to the goals of the agreement.

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You know, evidence is never neutral; like measurement, it reflects the context in which it is produced, and its value depends on how well it – that context matches the conditions in which it is applied. I mean, I worked in research for many years. We developed lots of interventions to work on university populations. Most people are not represented by young people at universities. Things that work for people who get to university don't work for underserved populations in rural Western Australia. There are different contexts and different settings, and what – again, we need to have – work around that, and we've got a program, we work with Curtin University; we've been doing it for several years, for developing a treatment – psychological treatment manuals that – and related training that reflect the specific treatment needs of underserved population groups.

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People, for example, at the moment we're looking at some material to do with people who have got sensory impairments, so are deaf. We're looking at some to do – I talked to Julian Trollor through the week about we're looking at developing some for people with an intellectual disability. These people don't get – that's a – there's
5 structural barriers in accessing care, because there simply isn't the training material; that's an example of infrastructure that's infinitely scalable, because we will put it on our website, anybody can copy it and use it, and we get to keep it too; it's like the Mars Bar you keep and give away, I think. Economists would have a word for that. I mean – isn't that - - -

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MR BUTTON: I know you do.

DR ROCK: And the other – then we move on to kind of what is, you know? To understand what's going on, for PHNs – all right – you need a fit-for-purpose
15 reference population, a denominator, you know? For WAPHA it can't be the whole of the WA population. We can't say, "How are we doing? Let's divide it by the whole WA population." Our funding, whilst generous, is kind of microdosing compared to the population level. And so when you kind of work out what the reference population is you realise where the topography of need is rather than seeing
20 that need embedded within a broader system of care, even if we're able to parse out what we're doing.

So define – more we're defining population groups by demography really limits informed decision-making concerning planning, because demography is only crudely
25 related to capacity to benefit, and having – also having many priority populations – and I'm not sure how many is in the agreement now, 16 or 17 – is almost the same as having none, because there's no obvious way of managing competing priorities. So when we think about it, we frequently use household income, because it's just – it's a convenient proxy for us. So we need to map – we also – related to that we also need
30 to map access to and through care for different population strata.

You know, when we examine the relative service accessibility for low-income households, the supply side map reveals these enormous healthcare deserts, not just in dispersed geographies, but within metropolitan centres, and the services are there,
35 but they're there in the same way as you have street-sleeping people in the shadow of hotels, you know, they're effectively inaccessible, but, in healthcare, they're undifferentiated is unlike the hotel situation and it masks the absence of services that are truly unavailable, and we're doing a piece of work with that – I was talking to Harvey about – Harvey Whiteford about this to try to start to do that, and doing
40 some work with the UQ.

And then what can be, you know? It's great to have laudable goals that go way past the knowledge horizons of people about what works, you know, into the unknown unknown space, but we need a realistic understanding of what can be achieved
45 through routine deliverable care in everyday settings and broad recognitions, because it's fairly – it's large, but it's known. We need to – with that, you need a realistic understanding of what's called a vertical burden. I mean, how much can be reduced

to routine delivered care? I mean, the vertical burden, as far as I'm aware, or burdens, is different from burdens for, say, for severe mental illness is about 28 per cent; that we don't get near that is artificial. That we can't go above it is because we don't know what to do. So it's separating out what's an artificial barrier to
5 improvement versus just we don't have enough knowledge to know what to do next, and recognising the limits that can be reasonably achieved within our current state of knowledge enables actually more expectations and highlights the gaps that are actually artificial. However, in any case, if you know it works and what effect it can have, yet systematic choices mean those interventions are not delivered, and these
10 omissions reflect decisions, not unknowns. You know, it's not like we're in that sort of Knightian uncertainty place or radical uncertainty. We're within the scope of what we know.

And to that end, we also support the development of the national planning tool and the planning support tool and we support that, and I know it's opened a lot of
15 criticism, and I'm both a critic and one of the people who develop the thing, so – but I think its modular architecture offers opportunity to better align the tool with revised agreement, and I think this modular architecture – it's a bit like Windows, the way Windows developed. You – you know, if you enable conditional access to
20 accredited developers, such as academic health science teams with expertise in systems modelling, like the group I'm aligned with is Acumen Mental Health, and PHN planners to build complementary modules, you can do that for the different subgroups whilst preserving the core system integrity and of the knowledge, the core of the system.

And we're doing a project at the moment like that. We're just – we're the first group outside of UQ to get permission to do this. It's with Monash Health Economics
25 Group, actually, facilitated by AIHW and department, which is computational add-on to the planning tool to model the burden of mental disorders that can be averted through interventions delivered in primary care for the populations we serve. So we
30 have for the first time kind of a reasonable scoping of what's the knowledge arising against which we can reference and beyond which you can think about, but it's kind of absurd to try and think you can step across simply because we just don't know enough, and I gave a talk the other – last year in Canberra using that well-known,
35 you know, "We look through the glass darkly."

You know, we have this kind of idea that – people have this idea we want to predict what we're going to do in five years' time when we can't work out what the interest
40 rate is going to be in three months. It's kind of – do you think we can plan a care system that well? So that's the kind of setting. It's about using the current really powerful tools, and they're remarkably powerful, and I think the – they're often discredited, and the people who develop them are given sort of short shrift when, in fact, they've delivered remarkable value; it's just that we need to use them a bit
45 more smartly, is my view. So that's a very long intro, but I'm happy to discuss any and all of that or other matters you want to discuss if I can possibly help.

MR BUTTON: Thanks, Danny. We appreciate that. And you'd have heard, I guess, some of the last – I'm not sure whether you got an opportunity - - -

DR ROCK: No. My system – I could see your mouths moving but I couldn't - - -

MR BUTTON: No, look, that's okay.

DR ROCK: I couldn't hear a thing. I can guess what Kerry said because I can channel her at times, so - - -

MR BUTTON: Yes. That's all right. And if we focus on the tools, and the planning itself, and I guess we're – certainly through the consultation process, and in the site visits around the place, for us, it became fairly evident that the consistent application of the tool just wasn't there in the system, and so fragmentation appears because the tool that was used to support, I guess, both PHNs and as well as LHDs was used inconsistently, and so you're going to get inconsistent commissioning. You're going to get inconsistent approaches.

DR ROCK: Yes.

MR BUTTON: So I guess my question is I think we're certainly of the view at the moment that the tool is important, but have we had a capability-building strategy around the tool to make sure that a consistent application does exist?

DR ROCK: No. Would you like – I can give you a longer answer, but no, because the tool was developed in a time and context with certain assumptions that are no longer, you know, tightly bound. I mean, the tool assumes – because it uses prevalence – that nothing changes, so you're designing a future on the basis that you're going to have no effect. Now, that's a – the – what I think about these tools is we have to be really careful. So a tool is just a model of the system. It's not really the system. It's what a statistician called Savage called a small world, so you take away all the complexity of the real world and you create a model. And it's a single ensemble model of the system.

And you can draw insights from that. That's it. If you think it's predicting the future, we're not that good because it – I mean, if I could – I mean, I'm involved with this stuff for 35 years. If I could do that, I'd be at Randwick. You know, like you can know a lot more about horses and make a lot more money, and we can't. So the system just gives you a perspective against which you have to, you know, use judgment and expertise. It's just a view. And I think what we focused on is the technical aspects of the tool because we talked about – you talk about the tool as if it's the planning framework. The planning framework is a whole lot of other judgment-based architecture on which the tool is one aspect of it and it's useful.

I think you need to go, okay, back to the actual planning framework. So what is its intents and its kind of assumptions? And then say this is but one tool that helps that. There are other tools, too. There's a planning – the planning tool can't map services.

It can't tell us what is. We know there's work trying to do it and attempts to do it, but it doesn't tell us what it is and doesn't tell us what's going on. It just describes some, if I can say, normative future state. And on its own it's a single tool for doing something that is exceptionally complex, whereas say if you do it with the systems
5 modelling stuff that I do with Acumen, again, they're single systems, but you can bring together ensemble models, and then say, "Well, you know, this is what we think."

It's – but you need people trained in using the outputs of the tool to inform decisions
10 and exercising judgment, not thinking absurdly that it's like a machine for generating a plan. It's not something you just sort of put these inputs in. It's not Ken Henry's big model of, you know, input-output. Even that – it's just a useful tool in the right hands. It's based on the users having expertise. It's not for the – and I think its simplicity belies the complexity of its interpretation is a way of putting it. That's
15 how I would put it, and we simply haven't invested enough in the planning side, so if – to be – something silly.

While I talked about standards and I talk about the need for planning standards, during COVID, I was sitting here in my studio in the garden and talking about these
20 sort of issues. And at the same time, I was getting a new garage door, and I live on the coast, and there's a wind criteria, and I had to get a structural engineer to sign off on my garage door. All right? Behind me here the coast. Yes, I only did that for a garage door, yet I could talk about and design health systems and no one checks. So people can use the tool but there's no checks. There's no qualitative checks.
25 There's no standards around how we apply this stuff and standards to contain the decisions we make.

So in health services, when I worked in health, there's planning standards because you have to work within the health national standards, safety and quality. It's
30 become disembodied. That's what I think. And, therefore, the framework can't be provided by the tool. The framework has to be provided by the context in which the tool's used, so that you can make a judgment about whether the tool fits the context, not whether the context fits the tool. And does that make – and I think we get that the wrong way around a lot because we've got this useful hammer and we want to go
35 around hitting stuff, and it doesn't work, and then we get upset because we go, "Oh, this tool's not working."

Well, yes, because you're applying it to a population of 12,000 people. You know. What do you think's going to happen to prevalence estimates that are for rare
40 diseases when you apply it to a population of 12,000? It's – so training. I wondered why we don't have national courses in training and why we don't have a national process around training people for health service planning if it's that important. Well, do we – as I said, is it just something that we incidentally do because we've got the time to do it and we think it might help? It just doesn't seem to be giving us the
45 same urgency as other things.

DR JACKSON: You might be able to answer this question. If we looked overseas, for example, and I'm thinking nice if we have.....

DR ROCK: Yes.

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DR JACKSON: These types of standards, that it would

DR ROCK: Yes.

10 DR JACKSON: Yes, and guidelines.

DR ROCK: Yes.

DR JACKSON: So that type of best practice.

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DR ROCK: Yes. Yes.

DR JACKSON: "This is what's expected of you," and then people actually do it.

20 DR ROCK: Yes.

DR JACKSON:

25 DR ROCK: Yes, because then you get what psychologists call "common method variance". You know, like, what you want from it is the same thing you don't want from choices. You want common method variance. You want people to apply it in the same way. And then decisions, of course – you want – decisions you want to frame using diversity, you know, because you want several people in the room who have different perspectives on the same fundamental problem. If you go around
30 trying to redefine the problem all the time, that's a problem. So you want instrumental diversity. You want people who can take a different way of solutioning this and understand the actual solution sits in the space between you, not between your ears, and I think that's a discipline that's missing greatly because – well, it's missing. I won't – I can't give my personal opinion why I think it's missing because
35 my colleagues at WAPHA would probably disagree with me.

MR BUTTON: Are there examples of where it is done well, Danny?

40 DR ROCK: Yes, but the frequently cited examples are not the places where it's done well. So the frequently cited - - -

MR BUTTON: That's okay.

45 DR ROCK: Trieste is always – was mentioned. Okay. Trieste – mental health services in Trieste are this, that and the other. Trieste is at the end of a cul-de-sac, and the place next to it can't replicate it. Okay. If the place next to it – the rule of geography is basically you – you know, if the place next to it can't do it, doing it

in Geraldton is not going to happen, you know. Everything is connected, but closer things are more connected. Are there places in the world that does it well? Yes. There are places in Europe that do it well. There are places like Chile that's not – that do it well. Parts of Canada do it well.

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There's nowhere that does it that you can just – that is completely exchangeable with Australia. So I think what you do is you go and say, "Well, this is what they've got. What do we want to take from it?" So we plan, for example, our suicide prevention services around the European Alliance Against Depression. Why? Because that suits our context of regionality in Western Australia, and it fits the context. There are plenty of other models for planning suicide prevention, but we – we've looked at the context in which we work and taken that model and adapted it to our setting and then built the architecture into – around it. Andalusia in Spain you can look at. You can look – but there's many different places.

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There isn't, however, the equivalent of an Ikea flat-pack somewhere that we can all go to. The places I've been to with ministers are always very lovely, by the way. They're never really rubbishy working-class places. They're all beautiful parts of Europe and stuff, but they just happen to have good mental health services. What I think we need to do is - in making decisions about what you choose, often people use this kind of part of a model that says, "We use – we look for a solution that's satisfactory and sufficient, you know, that satisfies the emotion." People forget the first part of that approach to making – you know, kind of, contains choices is search.

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You need to go and – we need to do a proper search, not for every possible thing we could possibly do, just for a sufficient number of possible things we can draw from, and then from those, choose a smaller number that are satisfactory and sufficient for what we do, above and beyond what we've got now, but not – not to create more bureaucracy because – you know, the bureaucracy on its own just creates effectively administrative harms that overlay all the other stuff we're doing. We don't need more bureaucracy. We just need a better calibration of our tools in relation to our decision structuring and being really much clearer about that.

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I would say there are places in Australia outside of health care that do this much – do this really well, and I don't even know is economics, but working with Monash and that group I have done for several years changes the way you think about – how you think about decisions, and I think we should be looking to areas perhaps within Australia, but with – outside of mental health that are really interesting. I work with a colleague now who came from RFDS, for example, who operate both an airline and a primary care system, and how they work is just so interesting because they literally have to deliver things on aeroplanes. So if you put an extra resource on, you have to take something off, and how they do that and the models they use around that resourcing is kind of fascinating. And there's others.

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I mean, I could tell you – I've done models using fish farms to emulate beds and stuff, so – but there's plenty there. We just – some sort of – I said in a paper recently the expertise exists in Australia, I accept, is just widely – it's just widely distributed

and unequally accessed. So we've got plenty of resources. In a digital world – in a world that was not digital, yes, that's understandable. In a digital world, that's not understandable to me because - you're sitting, I'm presuming – is it Canberra or Melbourne or Brisbane or somewhere? I don't know.

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DR JACKSON: Melbourne.

DR ROCK: Yes, and I'm here. So the spatial stuff doesn't – is not – doesn't impose as it used to. Some of the best mathematical system models in the world in health care exist in Australia. Where did they go and work? Where is that work in – you know, they get grants overseas even though they stay here. That's a loss of, you know, sovereign capability. And it's great that they can do the work. That is directed at Alberta or directed at Chile, is – or Spain is somewhat, you know – I think that's something we could exploit to a far greater extent.

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It probably needs a national body to do that – bring that together because – I honestly say the acumen work that Harvey set up, and I worked with him on that – my colleagues are very - very collegiate. They're not naturally sharing in the competitive world of academia, and I – I think they're the sorts of institutional changes that we require, simply for PHNs. You know, like, we've got 31 of us and we need a instantiated you know, cooperative at the top of that as well. So – and then there's a whole bunch of other stuff around how it identifies numbers and stuff and how you set but they're mostly just technical, kind of, fiddling that you – they're not fundamental limits.

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What – I think I mentioned in my material one of the things that's striking to me is not - this is not unknown. So AIHW published a report, and I think I referenced it, and I think it was in 2014, that showed the gap – the gap in health outcomes between people who are economically advantaged from those who are economically disadvantaged – 50 per cent of the gap isn't social determinants and stuff, it's access to treatment. It's – but that's not unknown, and so if we're talking about disproportionate care gaps, within what we know what to do – we know what to do and we just need to, I think, think about the mechanisms we need to do – to have in place to realise that and act upon it, but perhaps this is where I think we go wrong.

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We have – I said about having 15 reference populations is the same as having none. Having 25 national priorities in mental health is the same as having none too. We seem to want to prioritise everything such that's in a way nothing is prioritised and everything is just done at a tempo that represents the urgency of the day rather than the future state that we would like to get to, than we can reasonably get to within the limits of the knowledge we've currently got, and deliver really decent care to people, as a wealthy country ought to. That's what I think.

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MR BUTTON: Danny, we could sit and chat about this so much longer, but we are out of time. I do appreciate you putting in your submission and coming along and chatting with us today. Fascinating, some of the stuff that you're doing, and certainly hope that we can use that in the work that's going forward. As you

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mentioned, it is very much about how do we use – better use the tools that currently exist to improve what’s happening in the system, and I think that’s certainly a key theme we’ve heard from you today that we can take away. So, look, thanks very much for joining us this afternoon and thanks for sticking with us through the tech troubles.

DR ROCK: Yes.

MR BUTTON: Really appreciate your time, and I’m sure we will hear from you again shortly.

DR ROCK: From all the things I’ve said, I’m happy to provide the references for our material or talk further and provide more detail because I think it is – I think you’re – it is worth the effort, you know, and I would hate to think we give up on this sort of thing because it’s – it’s within our capacity to do it. That’s the - - -

MR BUTTON: Look, absolutely. If there are things that you think would be good for us to see and – to some of the reference materials and research - - -

DR ROCK: Yes.

MR BUTTON: - - - you’re talking about, happy for you to send that through to us as well. That will be great.

DR ROCK: Brilliant. Thank you both very much for your time and for listening.

MR BUTTON: Thanks very much.

DR JACKSON: Thank you. Thanks very much.

MR BUTTON: And that concludes the public hearings for today. Thank you.

MATTER ADJOURNED at 5.06 pm UNTIL WEDNESDAY, 20 AUGUST 2025