Review of the National Mental Health and Suicide Prevention Agreement

TRANSCRIPT OF PROCEEDINGS

O/N H-2045720

PRODUCTIVITY COMMISSION PUBLIC HEARING

MR SELWYN BUTTON, Commissioner
DR ANGELA JACKSON, Commissioner

DAY TWO

WEDNESDAY, 20 AUGUST 2025

DR JACKSON: Yes. Okay. Great. Good morning, and welcome to the public hearing for the Productivity Commission's review of The National Mental Health and Suicide Prevention Agreement. This is day 2 of our public hearings. I would like to begin, of course, by acknowledging the traditional custodians on – of the lands from which we are meeting today, the Wurundjeri people of the Kulin Nation, and pay my respects to elders past and present. My name is Angela Jackson, and I'm a commissioner with the Productivity Commission. Today my fellow commissioner, Selwyn Button, and I will be leading this public inquiry.

The purpose of these hearings is to facilitate public feedback and comment on the recommendations and findings that we made in our interim report, which was released in June. Following our public hearings, we will be working to finalise a report, and hand it to the government in October this year, having considered all the evidence that has been presented at the hearings, the submissions that we receive in relation to the interim report, and further analysis undertaken for 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 hearings in a reasonably informal manner, 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 the day'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 and A function to provide information. If you want to contact the review team, you can post a question in the Q and A, which only you and the team can see, or you can email the address provided in the Q and 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. Presenters' 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 do apply. No broadcasting of proceedings is allowed, and taping is only permitted with prior permission. Members of the media should email the address provided in the Q and A who can provide them with further information. Participants should be aware that media representatives present may be using social media and other internet mechanisms to convey information online in real time, including participants' remarks. We have a counselor with us today, Natasha Belmont, from Relationships

Australia Victoria, for anybody who would like to chat, or needs some additional support.

If you would like to speak to Natasha, please email the address provided in the Q and A, or use the Q and A function to send a message to the team. People appearing in an individual capacity today will automatically be allocated to a breakout room with Natasha after their appearance has concluded. Now, I would now like to welcome our first presenter for today, who is Jane Jervis and, Jane, I believe you're online already and ready to join us. Thank you very much.

MS J. JERVIS: Good morning. Thanks for the opportunity to speak with you today. I will focus most of my comments on harassment and bullying in the workplace, and harassment and bullying in the welfare system. I've been at a Productivity Commission hearing before about six years ago for the Mental Health Inquiry, but since then, my circumstances have been and are worsening. As per my submission for this inquiry, after doing a lot to re-enter the workforce, I had a terrible contracting experience, and then I was harassed and bullied on JobSeeker, which is tragic anyway to have ended up in the welfare system, and it's hard to put into words and to describe in full.

There are real world and real life impacts from bullying, and now since it's a range of impacts that are cumulative over years, it's exhausting, wearing me out, and bringing me down further. While being stuck below the poverty line, and under a gamified process to meet a target, which is largely compliance as well, and doubling up on what I already have to enter into the system myself. For the person who's affected by bullying, everything's bad. For the bully though, it seems easy, allowed to occur, and they often get away with it. It's rife in the public sector, which is where I spent most of my time, and I really loved my job and my work, and the purpose that I had, and the contributions that I could make, and it was said that it's even rife by the facilitator when I did the Commonwealth's health and safety training about eight years ago, and I was also harassed and bullied while being a health and safety representative in one of the large government departments.

So this isn't me as a resource being put to my highest value use. It's wasteful, leaves me having loads of time doing nothing, when I could be contributing, and that means ample time being ever presently aware of my circumstances, and with time to ponder what is the role of an Australian citizen, and a person's place and role in society, and what does the economy provide for and want out of its workers, but also what can workers expect in terms of their rights, and are those rights upheld, or is there an incongruence between what is said in the workplace, that we take it seriously, these issues like bullying and harassment, versus the reality which often is management and HR taking no or slow action, or not wanting to get involved, or taking a position of neutrality, or waiting for you to give up and it all will go away.

Even in response to a basic question these days, and since I have been in the workforce, about what do you do, I'm at a loss and I'm – what do I say? And a job, work and employment is more than just your pay and conditions. There's a lot of

aspects attached to how you perceive yourself, how other people perceive you and how you think that you fit and belong. I almost pulled out of this hearing, and one was suggesting it – sorry.

DR JACKSON: Take your time.

MS JERVIS: Yes. Another gave the despondent view again that nothing will come of it, while another cautioned how much is enough or too much for you personally, and another said get a lawyer for compensation, damages and reinstatement. I've also elevated as many places and as many times. I think I said that in the Mental Health Inquiry as well, doing everything that I can, including to the Prime Minister, which would have been cc'd to ministers, department heads and central agencies, about what's the answer in relation to what has happened and happening to me, and I've said the lot should be independently and externally looked at.

And what I say does relate broadly, as when the mental health report was published five years ago, it estimated that workplace bullying cost Australia's economy 30-odd billion dollars a year, and that's a massive, massive number, and there's some years where I was lost to and outside of anything, whether it's work or welfare, and not in a state to be fit for work because of the significant health impacts. And in recent years, I've tried to throw my all into it to return to the workforce, but it's seemingly more like a bit of a tragic existence, in that I won't survive in this stuckness, and it's groundhog day, the definition of stupidity, doing all of these applications and getting all of the rejections, and I'm trying in all different ways.

I'm trying for permanent employment, temporary employment, merit list, the – yes, all different types, and it has retraumatising, distressing and pointless with the interactions with Employment and Workplace Relations, Workforce Australia and the employment services providers, which don't actually help jobseekers. I would say that in first-hand experience, but it costs a lot in overheads and operating costs, but it's more just like money for jam for the middle people running these companies and organisations that we outsource, and taxpayers pay for, but they're not actually doing anything about getting people into work.

Last time I spoke for the mental health inquiry, I think I was a bit more fired up, whereas this time around I feel quite tired, upset and even more at a loss about what I can sort. And it's made harder if there's an expectation that I need to do more, try more, help more, be deferential and smile when that's just not how it is and it negates my experience, what I'm going through, and puts it all on me when I shouldn't be in this position in the first place because I'm out of work because of being mistreated in work and reporting and having it covered up and all of that sort of thing.

But then what if I did get into something that was appropriate and fitting in the workforce and in a good environment that reflected what I'm experienced in, capable of and used my potential and where I'm valued? What a relief and a lifting effect that would have, and it'd cease what I hate, hate being a strong word, but I hate being below the poverty line on the JobSeeker Payment and its associated compliance

processes that don't assist in getting a job. Being put through that for such a long time, it's unsustainable, a waste and it does more damage.

How we treat one another and how we prevent bullying/abuse remains relevant. In my statement last time, I mentioned power, status and control, and in my additional submission last time I mentioned honesty, integrity and accountability. Bullying exists. It's still happening, so what else is going to be done about it? In many places and many different ways, I've put in my suggestions for recruitment and selection, monitoring, reporting and zero tolerance, but bullying that's enabled will get amplified, and those bullies will just go higher up the hierarchy. It won't get the best out of or model what it is we say we want, and it has real world, real life, devastating negative consequences, and that gets back to that 30-odd billion dollar figure. Thank you.

MR BUTTON: Thanks, Jane. Really appreciate you appearing today and providing us with your experiences. I know it can be very, very difficult, so thank you for sticking with us and thank you for having the courage to come and chat to us. Couple of things I want to touch on in terms of questions, because what you've talked about is your own personal experience, but if we think about it, then, in terms of the agreement itself and at a macro level, what – in systems, the two component parts that you've described is an experience within the workplace, and then the experience as a job seeker then attempting to get back into the workplace.

And the terms of reference for – the scope of the terms of the reference for our review – certainly what I'm keen to understand is the space that you're in as a job seeker and navigating through circumstances and to get back into the workforce through appropriate services and agencies. What are some of the suggestions or things that you think might help job seekers that are also having some mental health experiences through that process at the same time that we might think about in that space particularly?

MS JERVIS: I would ask that they question the model that's being used, if it is overly compliance-focused, is that going to assist job seekers if – and I have mentioned this to DEWR as well, and all the cascading levels through that process, so who has responsibility for the overarching policy settings, but yes, it just does not help you if it gives you the impression that we just want to double-check what applications you're putting in to meet some target that is set up in the system but there is a human element behind it.

So those employment services providers who are supposed to be checking with you fortnightly and they can look at what the target is, I've found it quite awful when they focus on the target and the number of applications and sometimes I have even gone there and they've said, "Why are you here?" and I'm like, "You've set the meeting." And there's no – they don't give anything extra than what I'm already doing, so every day, Monday to Friday, I'm searching for jobs, applying for jobs. All they're doing is double-checking what I'm doing, and I would just question whether those overheads

and operating costs are worthwhile if they're not actually doing anything to place people into work.

I had one reference over the last year which was, "Be a receptionist." That is it. And I've never been a receptionist. No offence to receptionists, but to me, that just made me feel terrible as well because it felt like it was nothing to do with what I've done before, so yes, I think there's a lot of waste in terms of how the JobSeeker program under the mutual obligation side is structured. There would be other models that they could compare with, like the Commonwealth Employment Service or something like that, where it is more designed to make people's qualifications, skills and experience matched up to jobs, but then on a personal level, too, I'm still gobsmacked and all the rest of it about how I'm in this situation when I shouldn't be in it in the first place.

I know things have been said that they should be better than what it was like for me prior if people were going through these experiences. There is said to be more to address harassment and bullying and undermining and all the rest of it, but I – I shouldn't be being put through these processes. You know, I was – I was a contributor. It's the opposite of what was claimed, actually, in that what I did and what I provided was okay, and I struggle with actually knowing now, like I just said before, what do I do? Like, how – and I – that's why I've said what is the answer?

Because I can't do – like I feel like I'm on a rollercoaster on a hamster wheel, that groundhog day, doing the same thing, and people say live in the now, deal with the now, but also I can't help but think about, you know, what does the medium and long term look like now, particularly at the time that – and it's happened to me repeatedly, so I know that to meet the definition of bullying, it is – it's not just a once-off. It's, you know, targeted and it's repeated, but to have it happen over and over again, that does take a toll. But, you know, then it's – I don't think it's a question of am I strong enough, gritty enough, resilient enough?

This has taken a hit because of the wide-ranging impacts that it's had that are cumulative, so it's – that's why I've said what's the answer? I can't stay stuck like this. I – you know, temporarily now – and they've actually told me, so DEWR investigators. They did a couple of investigations, a couple of reviews. One of the people in the employment services provider said they've been hostile. They said, "Get a medical certificate," so I've got that until currently November, but they've said that's, you know, the minimum amount of time, so there's an expectation there that I might need that for longer, but I would dread going back to more of that compliance stuff again.

I would dread just continually, every Monday to Friday, having to do the same thing and not get anywhere, and yes, medium to long term, this is just not – like, there's this but then there's other bits of work that the Productivity Commission and elsewhere's doing on productivity and getting the best out of resources, and this is not – all of what I've described, this is in no way personally good for me, but it's in no way a good example either about, you know, taxpayer funds for these big

overheads and operating costs, but I get below the poverty line amount myself, with yes, just all the time being – knowing that I'm not doing anything, and yes. Sorry. I'll probably talk about it for ages, so feel free to ask the next question.

MR BUTTON: Look, I do absolutely appreciate. I'm conscious of time. Certainly wanted to make sure at least we give you the opportunity to speak and for us to ask some questions. We do have to move on to our next guys, but what I am hearing, though, if you bear with me, Jane – the experience you've had, particularly in the job seeker space, is that you – it's very much a compliance system that's set up to support people as opposed to a – really a person-centred system.

So there's no – we need to think about how do we humanise the process to then support people because we do have vulnerable people that are going through a system to try and access support and then get back onto – get back into employment, etcetera. The focus of compliance doesn't help and support that along the way, so that's certainly something that I can – we can take away from this discussion today, and certainly there does need to be more, but, as you mentioned, in the workplace and certainly those are the sorts of things that we can think about in our deliberations. What are the recommendations that we then provide at a macro level back to focus on a human-centred support system within the welfare space, but also, then, what's happening in the workplace to make sure at least people are supported through whatever process is occurring. So - - -

MS JERVIS: Yes, and it's clearly not working, though, as well. Like, I don't think this is just tiny little tweaks that they make. So I don't think them leaving things as they are is good enough, so I think they really do need to look into these things in greater depth about what are the structures, what levels of involvement are needed or not. So I would actually question, you know, if DEWR, Employment Workplace and Relations, is the policy arm, I would really question what does Workforce Australia and those employment services providers that get big money for the compliance – those last two, I would really question what is that doing or not doing and is it necessary, and then back to the – yes, what is the appropriate model that's required, where can they save money and where can they reduce the levels of interaction that the client has to unnecessarily go through without any benefit.

DR JACKSON: Look, I will say, Jane, and I think Selwyn has made this point, like, this inquiry is focused very much on the agreement between the state and the Commonwealth, but I know that there are other inquiries in train that the government's currently considering. Parliamentary inquiry last year, the Hill inquiry, that goes very much to your point, and I think the issues that you've raised.

They are – this is not the first time I've certainly heard this in recent times in terms of a system that makes life harder and makes getting a job harder rather than supporting people back into work, and that there is – there are things happening in the system at the moment and certainly, you know, in – I just want you to know that your voice is very strong and very powerful in terms of what the human impact of this is, and for us today, a privilege to hear it.

This is being heard at higher levels, and I think, you know, I can't promise anything because obviously government decides these things, but I think that idea that we've created a system that's a compliance system rather than supporting people back into work has been heard and certainly came through the Parliamentary inquiry and their findings, and the government is currently considering that and changes to the system that should better support, hopefully, people getting back into work in your circumstances in future.

MS JERVIS: Yes, and definitely they've still got more to go in the actual practical applications of things like zero tolerance to bullying and handling those matters better so that people don't end up in the situation that I have. Yes.

DR JACKSON: Yes.

MR BUTTON: Thank you very much for joining us and providing your presentation today, Jane. Really appreciate what you said and hope things go well for the rest of the day.

MS JERVIS: Thanks.

MR BUTTON: You will be now shifted into the room with Natasha, given you're an individual participant in the process, so automatically you'll go into the room with Natasha. It's up to you whether or not you want to have the discussion and use the time, but certainly part of the process for us is every individual participant who appears at the hearings will go to the room with Natasha, who's a counsellor online with us today, as well.

MS JERVIS: Thank you.

MR BUTTON: Thanks.

DR JACKSON: We have, I think, a five-minute break now before the next .....

ADJOURNED **[9.56 am]**

RESUMED **[10.01 am]**

MR BUTTON: And we're back - and we're back again for the public hearing. Our next participants presenting are from the Turner Institute for Brain and Mental

Health with Monash University, and we have Professor Mark Bellgrove and Professor Sue Cotton joining us. And Mark and Sue, can you hear us?

PROF M. BELLGROVE: We can hear you, but I think we're muted, and the cameras are off. I'm not sure whether you can hear us.

MR BUTTON: I can hear you and I can see Sue now.

DR JACKSON: Yes. And -yes.

MR BUTTON: We've got both of you. Excellent. How are you both?

PROF BELLGROVE: Well, thank you.

PROF S. COTTON: Good, thank you.

MR BUTTON: Thanks very much for appearing today. Really appreciate your time. What we would like to do is to give you the opportunity to provide a bit of an opening statement, to then talk about what you want to present and the priorities that you think are necessary for us to hear through the process of the inquiry, but certainly giving you the time to give an opening statement, and then we can get into some questions after that. At the commencement of your opening statement, if you could both state your names and title and organisations you're representing, and then we can go from there.

PROF BELLGROVE: Sure. Thanks. So that's for me to kick off. My name is Mark Bellgrove. I'm a professor at Monash. I'm the director of the Turner Institute for Brain and Mental Health. My own background is actually a neuroscientist, but I have a keen interest in mental health and particularly working with those with neurodevelopmental conditions, ADHD and autism predominantly in my own work. Sue Cotton - I'll allow you, Sue, to perhaps introduce yourself. You'll do it better than I will.

PROF COTTON: Okay. Thanks, Mark. So I'm Professor Sue Cotton. I'm now based at Monash University as a professor in psychology. I also hold honorary appointments at the University of Melbourne in the Centre for Youth Mental Health and have previously spent 21 years at Orygen leading the health services and outcomes research team. So I joined Monash in June last year.

I also am the director of the Centre - NHMRC-funded Centre of Research Excellence in bipolar disorders and also lead a NHMRC partnership grant working with the Victorian State Government Headspace National and Ambulance Victoria to identify care pathways for young people with mental illness in Victoria across sectors. Thank you.

PROF BELLGROVE: Okay. So look, I'll just provide a little bit of a overview and a bit of context-setting, I guess. So the Turner Institute for Brain and Mental Health

at Monash is the research hub of the School of Psychological Sciences that represents over 120 researchers, 175 students. It both serves an academic purpose in that we're doing research to really provide the evidence base on which future policy around mental health may be built, but it's also obviously a key training facility for psychology graduates. We train over 3200 psychology students across all levels from undergraduate through to clinical PhDs, neuropsychology and clinical psychology, and we also run the Turner Clinic, which services over 3000 clients per year, so very much the outward community face mental health treatment for folks.

So what we'd like to focus on today in our submission, I guess, are three core areas that we feel, I guess, we can speak to robustly. We're happy to take other comments from you guys regarding our submission. But I guess the three core areas that we'd like to focus on are really around the topics of psychosocial support, lived experience and data collection sharing and linkage that are outlined in the interim report.

And the first one about psychosocial support - and I'm just sort of going to give you an overview and then Sue is going to dig in right into the weeds as much as you'd like her to. But the term "psychosocial support" is really referenced pretty broadly in the report, but I think it's - definitionally, it's very poorly defined in the report, because it means many different things to many different people. And I think from the outset we need much greater clarity around what psychosocial support means and much clearer definitions, because I think that ambiguity is not helping us here in the report, and we need to, I think, lock that down much more precisely.

The second area is lived experience, and we note again in the interim report that really multiple terms are used throughout to represent stakeholders, and again, there's a need for consistent language and to have a clear, inclusive and representative definition. And you'll see in our report that we've put to you we really focus on using a framework, such as the Four Ls framework, that really categorises stakeholders into four groups: either those with a lived experience, a loved experience, a laboured or a learned experience. And we think this type of definitional framework could really be useful in the reformulation of the agreement.

And the third area is very much around data collection sharing and linkage, which I know is very dear to Sue's heart and on which she's an expert, and that's really about chronic issues with data collection, sharing, linking and infrastructure. Really underrepresents the true burden of mental health and its impacts on our ability to be able to map people's pathways of care and services right across the lifespan. I think there are also issues there regarding appropriate tools for measuring outcomes in the long term and so that we can show improvement against the stated objectives of the agreement. Do we have the appropriate measures to actually be able to show improvement? And again, we'll dig into that.

And an example there is routine outcome measures that are used by governments and service providers, such as the Health of the Nation Outcome Scales, HoNOS, were developed years ago without meaningful input from consumers or clinicians, and I would argue also without probably the cross-cultural knowledge that we need in

today's society. So I will let Sue jump in and go into more details in those three key areas. We can chat about other areas as you wish as well.

PROF COTTON: Thank you, Mark. You've really given a great introduction to our three points. And feel free to ask any questions as I go through. So psychosocial support is a term, I think, used really quite widely. And also in reference in the report about psychosocial supports funded by NDIS and those not. The emphasis in the report is around focusing on those services that are not funded by NDIS or individuals not on NDIS.

We want to raise the issue more broadly, is that the psychosocial support can mean anything. And I think in - the last speaker particularly was referencing the difficulties in employment sector and supported services. These services are not necessarily providing evidence-based care. For example, we know from work that we've done at Orygen with Eóin Killackey individual placement support is ideal evidence-based intervention to support people getting back into the workforce or education, and these such interventions are not widely offered in employment services.

So I also think that the evidence base for some of the services that come under the title of "psychosocial service" are not evidence-based and could actually be doing harm to individuals as well as costing the government money, and particularly around NDIS funding, but it's costing people money and potentially harmful.

I'm going to give an example of animal-assisted therapy. So we have – I have a student who's doing work in the area, and we're trying to develop the evidence base, but in, and animal are fun to be with and there are a lot of providers out there with no formal clinical training that are providing what's called animal-assisted therapy that is going to help, and I've seen – provide therapy or cures for autism or personality disorder. I will use the example of I will go and hug a cow for $250 an hour and that is considered therapy. So it does come under psychosocial support, but it's not evidence-based. There could be harm to the individual. There could be harm to the animal. And there's no regulation.

So I think it's really important across the sectors to get the definition of psychosocial support right, to review what is the evidence base for psychosocial services and ensuring that people get the right supports and access to the supports and across sectors. And I think when you do talk about psychosocial supports, you do need to consider outside of just the mental health systems. So you need to consider homelessness; other services, such as sexual assault, family violence sectors. There's a whole range of areas that we need to be considering just apart from the mental health systems.

And I think this is one of the other areas that we wanted to highlight in our report: that we need to not only just consider the mental health system, but other sectors as well. And that's really important, even across jurisdictions. And the 5W Project that I lead, which is also NHMRC-funded, is trying to get the sectors emergency

services, primary and mental health care, and the State Government working together to use data. I will come back to that more broadly in my last point about data collection, sharing and linkage. I want to talk about lived experience, and working with multiple stakeholders, lived experience is so important for progressing the work here.

MR BUTTON: Before you move away from psychosocial support - - -

PROF COTTON: Yes.

MR BUTTON: Not meaning to interrupt and cut your flow off - - -

PROF COTTON: No. That's fine.

MR BUTTON: If we focus on the questions about – because if we're chunking it up into the three component parts – I'm happy to do that, but if we can have - - -

PROF COTTON: Yes.

MR BUTTON: - - - some question time on the psychosocial support, that would be great.

PROF COTTON: Yes. No. That's fine.

MR BUTTON: We're happy – I guess the question for me – and certainly what we're trying to get at, in terms of some of the evidence – and we're agreed that we do need to have evidence-based interventions - or evidence-based suggestions around interventions and programs to be funded. So in saying that – and certainly one of the – as you would have seen in the report, part of our recommendations in relation to evidence is to make sure that evaluations and reviews of initiatives and programs are not only undertaken on a regular basis, but also made publicly available, so there's transparency in what's going on, in terms of being funded, as well as understanding the evidence that's attached to them.

Can you give us some examples, particularly in the psychosocial support – and you might focus on, I guess, the population that you work with predominantly, which is young people. What are some of the psychosocial supports that are working well, that have good evidence, that we can actually suggest as part of this process - to say to government, "Look, there's a missing middle here. There's the 500,000" - - -

PROF COTTON: .....

MR BUTTON: - - - "across the country, a large proportion are young people, and here are some things that we do know are working out in this sector, that we think you might be able to start to have a look at to make sure at least we're getting the scale up or implementing in certain places."

PROF COTTON: Yes. That's a great question. So I think as I highlighted, individual placement support is a really good evidence-based intervention to help people get back into work and get into the sector and providing a supportive framework to allow that to happen, so not just a tokenistic meeting criteria for applying for jobs, it's actually meaningful engagement processes and connecting with employers and getting individuals back into the workforce or education. So that is one.

I'm also going to highlight at the Turner Institute, Marie – Professor Marie Yap has developed a Partners Parenting in – is it Partners in Parenting? I always get the acronym confused. So a PiP intervention, which is now being trialled and tested in multiple groups and about supporting parents to better help their children in managing mental health concerns, and this includes engaging with external partners, such as headspace National, to looking at helping families that are navigating issues, such as school refusals, for example.

So there's lots of opportunities there, and that has now been trialled and tested for, I think, about 10 years, hasn't it, Mark, and really looking at – a wonderful program that's helping – I think it has helped over 3000 people – parents help support for young persons. So there are opportunities and trials that have been conducted in that area. Other work done at the Turner – Dr Kylie King is working with Roses in the Ocean, developing peer support networks for people – peer workers who have had experience around suicide to help train up others. So that's another area that interventions are being established.

PROF BELLGROVE: I guess more broadly, Selwyn, we would advocate for a rigorous assessment of the evidence regarding the psychosocial supports before they get to the point of being implemented with the community because there is a cost to the individual, in time, in finances, etcetera, and there is a cost to the government. So I guess what we're advocating for is that rigorous assessment of evidence that occurs in the first place, before we start putting these things forward as potential effective for treating whichever condition we might be considering.

MR BUTTON: Thanks, Mark, and thank you, Sue. Certainly with you on that and just making sure that there's evidence to suggest that the interventions and initiatives that are being suggested and funded are ones that we've got some solid backing around. So I will let you go on to the – you were going to go on to lived experience, Sue. Sorry.

PROF COTTON: Yes. So I was just talking about the – yes. I was going to talk about the lived experience and broadening out the perspectives about who are the key stakeholders in all of this. So I think as Mark highlighted, we can offer a lot in terms of testing psychosocial interventions, and we have a strong history in doing that. So in taking this to perspective, we need to consider who the stakeholders are, and I have proposed my colleague Eóin Killackey's model about the four Ls which has been published in Lancet Psychiatry, but it's not only considering those with a lived experience.

I think it's also important to consider that carers, supporters and families have different experiences, and it's important to recognise their inputs. I also think it's important to those working on the ground, and I think this is – like, clinicians, the service providers often get missed out. So there's no point running a new system or a new program if you don't have clinicians on the ground involved as stakeholders, and also learned – and the learned experts. And this is what the university can bring to this work. We can provide an evidence base for psychosocial supports. We can help with measurement, developing new outcome tools and evaluation.

And, also, we are training the next workforce. So we are training our students in co-design. What does that mean for research? Should they be considering getting out there and speaking with people with a lived experience, speaking with people with a laboured experience of working with clinicians, to make sure that we train up our workforce that is going to be equipped to move things forward. So I really want to highlight that – yes. It's really important to have lived experience, but to broaden out the key stakeholders because without all of the stakeholders, we cannot keep moving forward.

This is very much approach that I've had with the Centre of Research Excellence in Bipolar Disorder. Bipolar disorder, still the average delay in diagnosis from onset to diagnose and adequate treatment is 10 years, and we have some recent data to support that, but we cannot get the field moving and trying to work towards earlier identification, supporting families with bipolar disorder if we don't have key government bodies, key agencies involved in supporting individuals with bipolar, the individuals themselves, carers, loved ones, and researchers. So it's about bringing everyone to the table to look at addressing the issues, and I get the sense in the latest internal report it's still siloed, but we all need to be working together.

PROF BELLGROVE: Yes. It definitely doesn't fit – doesn't feel like it's being considered from the get-go. If the goal here is true co-production, where people with lived experience have a say in all stages of the process, all the way up to the reporting and the decision-making at the end – you know, that's a deliberative decision that has to be made from the get-go and really held to and held – people held to account for that – to account for that, you know, from the start, and so we very much advocate for the types of processes Sue is talking about.

DR JACKSON: I guess I'm interested – we've certainly heard a lot from people of lived experience about, you know, co-design processes, often feeling that their voices aren't heard or heard at the right times in a process and/or the power imbalance that can exist within existing frameworks and existing bodies. I guess it would be interesting to hear your perspective in terms of – as academics and clinicians. Is that a similar sense: that when working with government, that – or working on these policy design issues, that your voice isn't heard or isn't taken into account and your perspective doesn't feed through?

PROF COTTON: Most definitely. I think it is really still a hierarchical approach, top-down approach, and voices are not listened, and I can give an example, like the

CORE-BD. We're changing some of our research focuses to address what our – we've got a brains trust, and we're addressing what - and looking at opportunities to address what brains trust members are highlighting as key issues. So it's not only about hearing voices, but it's actually putting into action what are the key priorities.

So, for example, the issues around sexual health and bipolar keep coming up, particularly for women, and the nature of the disorder, behaviours like hypersexuality can place women in particular in really dangerous scenarios, so risk of STIs, risk of harms. So this has come up as a research priority working with our brains trust from CORE-BD. So it's not a top – it shouldn't be a top-down approach. It should be listening as well as putting into action – yes, and I think it's – it's about a partnership and trying to break down that hierarchy.

PROF BELLGROVE: I think I would probably emphasise that sometimes it's not easy. Right. You're having discussions at many different levels. It takes time. You're trying to allow voices to be heard, but the only way it works is making a firm commitment to it from the get-go and allowing that process to – you know, to see its way through because otherwise - if it gets derailed, the whole meaning of the process falls apart. So, you know, getting a commitment to it from the get-go and seeing it through, it takes time, it takes effort, but I think ultimately it's rewarding for all parties if it's managed well.

DR JACKSON: I feel like we need to let you go, so on to your final point around data collection because it's obviously an area of special interest.

PROF COTTON: Yes. Thank you. So data – and I suppose I'm a bit of a data nerd, so I'm going to own that. So I've got not only a background in neuropsychology but I did a master's in stats way, way, way back, so a lot of my work of interest is around measurement and understanding measurement and how we can do things better. One of the key issues – and when I was at Orygen, and I'm still leading projects there, I did a long-term follow-up of young people who were treated for early psychosis at AEPCC.

So we're up to 25-year follow up of this cohort of 600. And what I want to know is what happens to young people once they leave services. We don't have any way of knowing, from our current data systems, what happens to people once they leave a service. There is no consistency across the sectors, and there's no good way of monitoring whether people are actually getting the services they need down the track, and the research and from the people that we've interviewed, they're not getting into services. So once they leave early intervention, they're not getting into services. They don't meet threshold.

The other thing interested in is cross-sector engagement, and this is one of the issues that we're dealing with with the 5W study. We're actually looking at pathways through care for young people attending headspace, so – and looking at what other health, human and welfare services they're using after they leave headspace. But there are no systems in place to do that. I highlight recently we looked at a cross-

sector data linkage with Police Victoria for the early psychosis cohort. The numbers – we had no idea that we would expect such great numbers, but out of a cohort of 600, there are 7231 instances of offending behaviours and contacts with police.

Victims, being victims of crime, 704, which includes 63 cases of rape. Family violence, 2059 instances of contact with Victorian Police. IVOs, both as defendants and complainants, 205. Medical episodes where police are needing to be involved in callout, 871. So we don't have that data at access – it's not easy to access. But we need to know because we need to be working with different agencies to – and across sectors to try and address some of these issues. The – and it looks like, from the data, that the most – the first episodes are actually happening nine years after AEPCC, so they're actually happening over time, and we need to know where people are getting lost in the systems and the sectors. I think - - -

PROF BELLGROVE: I might just give a shout-out. Obviously Sue's got very high-level data analysis capabilities in that she's a data nerd, and thank God for that because really we need people like Sue. But I think a shout-out going forward – you know, if we're able to harmonise these datasets, we're able to integrate them, you know, we're on the verge of these great advances with AI supercomputers. The analysis of these datasets, if integrated, will become so much easier. Monash is investing huge amounts in Maverick an AI supercomputer that will make, you know, data analysis tasks, you know, really child's play with the power that it will have.

If these systems are knitted together, together in a way that we can gain these insights, that data provides huge amounts of knowledge. It'll help with surveillance with risk, with monitoring. It's a massive opportunity for the country, but currently, with our state system, it's very hard to knit these datasets together. And I think there needs to be a much greater commitment to that, which will help break down these silos that we have between the different systems, whether it be mental health, justice, etcetera. And I think the opportunity is immense going forward, I think, if we can – to really drive improvements in health outcomes for folks here.

PROF COTTON: So I think it's around capacity building, as well. Providing the infrastructure for the centres that do do data linkage. They're really overworked at the moment. It took two years to get population data for Victoria across all health and human sectors. Yes. The services are underfunded. We need capacity in both having content expertise around health services evaluation, but also we need the data scientists to drive this work. This is big work.

And we need, you know, to be engaging all the stakeholder groups, clinicians, service providers, government in this work. I think, you know, identifying the

services and pathways through care is going to be really informative for identifying the gaps in the services and where resources should be allocated.

DR JACKSON: Sue, are you able to share that analysis that you've just mentioned with the Victorian Police? Is that something that's published or - - -

PROF COTTON: Yes, it's not quite published yet. I have presented on it, so I've got a D-psych student, a Doctor of Psychology student, who's just writing it up as a final paper. So – but yes, I am actually happy to provide the summary.

DR JACKSON: Yes, that would be fantastic.

MR BUTTON: ..... great.

DR JACKSON: Very useful. I'm actually off to the productivity roundtable tomorrow, and I think that's some pretty decent stats to share with them in terms of how they might think about data going forward in these areas. Look, we are at time, unfortunately. Thank you very much. The other thing I might ask for you to do is you do mention a bit of a critique about our lack of definition. If you have a definition that you think would be better, please share, but otherwise, we are going to have to wrap it up - - -

PROF COTTON: Yes.

DR JACKSON: - - - today, I think, but thank you very much for your time and for your thoughts and feedback. It's really very – we're very grateful, so thank you.

MR BUTTON: Thanks very much.

PROF COTTON: Yes. Thank you.

PROF BELLGROVE: Thanks for the opportunity, and this is great work. It's very much needed work, so anything we say is only in the context of - - -

DR JACKSON: No, no. We're - - -

PROF BELLGROVE: ..... better outcomes.

DR JACKSON: We're not that precious. We've – that's why it's an interim report, so thank you.

MR BUTTON: Yes. That's why we're having these hearings - - -

DR JACKSON: Yes, yes.

MR BUTTON: - - - to get feedback.

PROF COTTON: Yes.

DR JACKSON: Thank you.

PROF BELLGROVE: Thanks .....

MR BUTTON: We've got to go to Stephen. Sorry, Stephen.

MR HOWALD: Good morning, Commissioners. Stephen Howald. How are you today?

MR BUTTON: Good.

DR JACKSON: Good, thank you. Thank you.

MR HOWALD: My presentation to you, I think, will probably be extremely brief. I think that there is a bit of a misunderstanding that I did make an application to participate in the public hearing, but as a participant listening to the actual presentations. But I may have some information for you just briefly about our service, which is lived experience. I know you've heard probably a lot about lived experience, but ours is perhaps an unusual entity. Would you like me to continue?

DR JACKSON: We would like to hear from you - - -

MR BUTTON: Yes.

DR JACKSON: - - - Stephen. Thank you very much .....

MR HOWALD: Yes.

DR JACKSON: Yes, and – yes, please.

MR HOWALD: Yes, all right. Look, thanks so much. And I might just acknowledge, please, the Darramuragal people of the Kur-ring-gai tribe and pay my respects to elders past, present and emerging and just acknowledge that we're living and working on Aboriginal land. Thank you this morning. And just also to acknowledge, please, all people with a lived experience of mental illness. I am one. I am a consumer of mental health services. I'm lived experience. I'm 56 years of age and I have bipolar disorder. One of the things that I have pretty well committed my sort of adult life to has been around mental health – mental illness reform. Mental health reform, I should say.

And one of the – well, two of the activities that I have is – well, one is a business providing services to children and young people with lived experience of mental illness. I've worked with DCJ here in New South Wales, DOCS and FACS, and provided a really amazing service for over 20 years, and this year I've started a charity, which is registered again in New South Wales. It's a lived experience charity, so, therefore, the – all of the board members are people with lived experience. All of the executive team are the same: lived experience. And once we are funded more fully, we'll engage a peer workforce, again, all of folk with lived experience.

Just where that business is at at the moment that, you know, we've had, like, incredible response from government and community, without the funding, of course, but, you know, really from the Minister's office all the way through health, police, community services, people love the idea of, you know, a complete lived experience program, and - yes, so that's - that really is the business options.

You know, we know that the Royal Commission Victoria Recommendation Number 29 did identify the need for an agency led, managed and run by people with lived experience of mental illness, designing, developing and delivering mental health services to people with lived experience of mental illness. That's what we're doing. We're pitching in that space, and - yes, again, so far, the interest has been, you know, exciting, and that's the space that we're moving into. I don't really have a great deal more to contribute to our call this morning, but I'd be happy to answer any questions and probably elaborate further on our program.

DR JACKSON: Great work ..... and it's fantastic to see. I guess from our perspective, from a systems perspective, you mentioned a lack of funding.

MR HOWALD: Yes.

DR JACKSON: Like, what does that mean for you in terms of, you know, day to day in terms of the planning ahead? What could change about the system so that that funding might be able to flow is it a lack of flexibility with local providers? Is it just there isn't the bucket that - - -

MR HOWALD: No, look, I think the commitment is definitely there to fund our service. What - we're new, only since March, and, you know, a lot of the efforts thus far have been in promoting, you know, exactly who we are. We haven't really put

any significant funding applications in, except we are doing that at the moment, and, you know, the supporting documentation that the Minister's office - Rose Jackson in New South Wales office, the Mental Health Coordinating Council and the local councils is just fantastic. So just sort of can't believe how people are onboard with what our idea is.

And yes, look, I was, you know, very much sort of doubting what support we would have from the start, so - yes, really, to answer your question, it's just a matter that we haven't made any significant applications, but we do expect that once we do, that we'll be successful.

MR BUTTON: Stephen, I'm going to ask you to draw on some previous experience in some of the work you've done in the past.

MR HOWALD: Yes.

MR BUTTON: And because it's something that we certainly grapple with in terms of the focus of attention, and where I'm going to go is some of the work you probably were doing in DCJ and certainly then working with - looking at, I guess, peer support for - peer support in out-of-home care and child protection systems.

MR HOWALD: Yes.

MR BUTTON: Because it's obviously a growing concern across the country - - -

MR HOWALD: Yes.

MR BUTTON: - - - I want to touch on what that looks like. What does peer support look like? What does care and, I guess, support look like for kids in child protection systems, in out-of-home care that's - that is non-clinical, and what were the outcomes you were able to get in that space?

MR HOWALD: Yes, certainly. Thank you. And, look, just a point: we are actually - even though we're unfunded, we are still continuing a service, so we have just over a dozen clients who we're servicing at the moment. We do that voluntarily. But the work previously and, look, currently, because there are current clients that we have that we're still servicing through the business model with DCJ - our program is a mentor program, and it's a mentor program both for our charity and also for our paid business with DCJ.

And what that is is a matter of connecting with a young person once or twice a week and engaging with them for all manner of activities, but what we find is because there are – there are young people who we're working with with diagnosis of conduct disorder, FASD and other types of, sort of, ADHD and autism diagnosis. It's usually difficult to engage, and, you know, what we sort of find ourselves is, sort of, chasing our heels most of the time.

A number of those kids that we're working with at the moment are on the street and have been for a long time. There's one in particular who's – who we connect with each week, a couple of times, one time at least because we help him with shopping, but – you know, look, his situation is quite dire. He's 16. He has been on the street since he was 14 and four months, and he's not in care of DCJ. They can't raise a good-enough argument that he needs to be in care when he has two quite satisfactory carers, but we attempt to connect with him just for the point of sighting him each week, but we have also made some inroads with getting him into a day program, into school, and so he is participating in school, but it's a – you know, a varied form, and he's – look, he's not doing so bad that way, but he still is taking drugs, and there are some suggestions that he's part of a – part of crime with – you know, like, you see these ..... gangs. It's possible that he's engaging in those types of behaviours.

So it's difficult, but the - generally the mentor program that we've run for many years has been very successful outcomes. Keeping kids in the placement has always been the greatest priority, keeping kids in school, and generally managing some of their abnormal behaviour. So – yes. That's – but that has been the work that we've done in that space. It's difficult work for some of those kids because they – you know, their behaviours are just so – are just difficult. Yes. Yes are there any questions other than that, please.

MR BUTTON: Certainly is important work because, as you would appreciate and as you would have seen, working in the system and doing the work you're doing, many of those kids that get caught up in child protection, out-of-home care, do become those kids in juvenile detention and - - -

MR HOWALD: Yes.

MR BUTTON: And progress to adult incarceration. So the more we can do at that front end, the better it is for them to remain out of, I guess, that custodial system in the long run as well.

MR HOWALD: Yes. That's right. And, look, using youth workers with lived experience, so their own problems as youngsters, has also been, you know, highly – highly positive. And, you know, those kids can really connect with youth workers who, you know, have, sort of, walked the walk, I guess, and have themselves, you know, had their own troubles and been able to, sort of, get through the either side. So – yes. Definitely lived experience in that space around the behaviours is really important.

MR BUTTON: A couple of quick broader questions, Stephen.

MR HOWALD: Yes.

MR BUTTON: The interim report itself: do you have any suggestions for us around things that you think we should focus on or improve upon in the interim report?

MR HOWALD: Yes. Of course, the outcomes and – they haven't improved. I think that is the one that stands out. The other, of course, is the stigma and discrimination reduction strategies. So I've had contact with Minister Butler's office, you know, regarding the release date – or the public release date. So if that were to be released, I think that would really help, so – and I think you seem to be already advocating on that part in the report. Yes. No. Look, I think those are probably the only ones. You know, the – I understand that it's difficult to be clear about what the outcomes here, either good or bad. You know, the measures are difficult.

Listening to the previous participant, you know, around, I guess, some of the data, I thought that was really interesting. Maybe there can be, you know, in the future better measures of what the outcomes are. I'm not sure if that's possible, but maybe that's something as a suggestion, and – yes, definitely the rates of suicide for Aboriginal people, Torres Strait Islander people are, you know, hugely concerning, but those – that's not new for anyone, but, you know, more can be done on that front, you know, I think, would be really great.

I don't know – don't really know what – you know, what the answers and what the report – the review will be about – yes, about what other recommendations on the local level will be. My work – or our service this year and previous years has really just been about one person and – you know, dealing with just – yes, just one life, really, and, you know, starting from there. I'm sure there are lots of services who do that, but, you know, that – that's our focus. So we would be interested in what can be done at the local level to – yes, to improve the outcomes. Yes.

MR BUTTON: You mentioned the stigma and discrimination reduction strategy. What would that – what influence would that have on the work that you're doing with young people? How would that start to change things? If we were talking about looking at this whole process of stigma and discrimination reduction in mental health and suicide prevention space, what benefit would you think we would – we should see with some of the clients you're working with?

MR HOWALD: Yes. Look, I think – you know, look, interestingly – interestingly – so the people that we're working with with our charity and – you know, look, those are some folk who are, look, really unwell; you know, who are using ice and heroin, who have been – you know, homelessness or in squats. Those are people who are not really concerned about stigma or discrimination strategies, but I think that – I think that having the opportunity for the wider community or society to engage with – or just the actual – that it's out there and that's something to refer to, I think, would be enormously useful, just to make things a little bit more realistic when it comes to, you know, diagnosis and – yes, and symptoms and understanding around – well, I guess about – about – yes, about people's response to people with, say, severe and complex mental illness, that people are just – just respond better, I think, have better understanding. So I think the tool actually can be used for society for better understanding and acceptance. Yes.

MR BUTTON: Last question I have for you, Stephen.

MR HOWALD: Yes.

MR BUTTON: You mention the data. You heard some of the data ..... before. What we're sort of suggesting in the interim report that you might have seen is around essentially what is – what's the public reporting and accountability component and whether or not we should go down the path of essentially what is a public dashboard for mental health and suicide prevention measures, and so really about highlighting that transparency approach. Yes. There's the work that needs to happen in terms of data linkage and making sure we're collecting and measuring the right things, but I guess in an interim step, do you think that public transparency of what's happening at the moment might be a good place to start?

MR HOWALD: Look, I'm sorry, Selwyn. I don't understand the question well enough to – I think to comment. Would you perhaps be able to reframe the question.

DR JACKSON: Yes.

MR BUTTON: So what - - -

DR JACKSON: I will try because maybe I'm clearer, maybe not. So what we're talking just about is publishing on a website all the, sort of, top level or even some more detailed local level statistics around how the system is performing and having a bit more transparency around that. We have Closing the Gap agreement, for example, on our website, and it just provides that more high-level accountability and whether – I think you're asking whether that would be something that would be beneficial.

MR HOWALD: Yes. Yes, of course it is. We work in the space with organisations like, say, Uniting, Salvation Army; Mind Australia, which I think are called One Door in Sydney; and another organisation called Stride, which is after-care, you know, and these are colossal organisations that probably are able to access that data and use that to disseminate, you know, between their, sort of – you know, with their key stakeholders. I would say for our work, you know, working, you know, on the street and, you know, working with people who, you know, have addictions, who are typically hard to reach and vulnerable, I don't – I don't see really any benefit to them, but the flow-on effect from bigger organisations or even – even our organisation as we grow, I think – I think, you know – I think any information is important, but I just don't see how there would be a benefit for – well, certainly there is a benefit for our team, but not for our clients.

DR JACKSON: On that – sorry. And I'm going to ask one final question now, and then we will let you go, I promise.

MR HOWALD: Yes.

DR JACKSON: So we've also asked more broadly about alcohol and other drugs and whether or not the next agreement should have a specific schedule dedicated to alcohol and other drugs. You've mentioned a couple of times working with people with addiction. I guess some of your reflections on how the two systems interrelate and whether or not having that specific focus in the next agreement might be beneficial or not.

MR HOWALD: Yes. Look, I believe so, but it's really tricky. So for three people who we work with, who have significant injecting, drug-using behaviours, I would say that their behaviours need to be addressed individually, but then there are others with lesser significance or lower using – sorry. The words. Who – whose – who can benefit from the drug and alcohol, say, treatments, for example, or therapies in relation to their therapies for mental illness. I haven't answered that very well, but - - -

DR JACKSON: No.

MR HOWALD: It just .....

DR JACKSON: Sorry. You have, but - yes. I think it – it's complicated and - - -

MR HOWALD: Yes.

DR JACKSON: - - - an individual approach is needed, but - - -

MR HOWALD: It is – yes, an individual approach, but I think for more serious using behaviours, I think it needs to be separated from what might be mental illness and suicide outcomes. Yes. Yes.

DR JACKSON: Thank you very much for your time - - -

MR HOWALD: Yes.

DR JACKSON: - - - and for listening in and for your – yes, for your feedback and for your interest in the inquiry. We really, really value it, and it has been great to speak to you today. We do have Natasha, who is a trained counsellor and as in individualyou will be going to, hopefully, a room with Natasha now. If that doesn't occur, she will probably give you a phone call after this.

MR HOWALD: Yes.

DR JACKSON: Thank you very much. And we will be taking a break now for lunch, and we are back online, for those who are watching, at 1 pm today with our

next attendee. So thank you very much again, Stephen, and to everyone who has appeared this morning.

ADJOURNED **[10.53 am]**

RESUMED **[1.00 pm]**

MR BUTTON: Thanks, everyone. We will now resume our public hearings for the Productivity Commission Review of the National Mental Health and Suicide Prevention Group. This was mentioned earlier, but for those who were not present, at the conclusion of today's scheduled participants, I will ask if anyone else 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. We also have a counsellor, Natasha Belmont, from Relationships Australia Victoria. She's with us today for anyone who would like to chat or need some additional support. If 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. I would now like to call Geoff Harris from the Mental Health Coalition of South Australia.

MR HARRIS: Hello.

MR BUTTON: How you going?

MR HARRIS: Yes. Very well. Thanks. How are you doing?

MR BUTTON: Very good. Thanks for joining us this afternoon. We will – before we kick off, I just wanted to – a couple of quick logistical pieces. When you start, would be great if you could provide your name, your title and organisation you're from and then kick into your opening statement, and once you're done with your opening statement, we can then focus on some of the things in terms of conversation and questions that we will ask about particular things that you want to prioritise for your appearance today. So I will hand it over to you to kick off.

MR HARRIS: Thank you. So my name is Geoff Harris. I'm the executive director of the Mental Health Coalition of South Australia. I think firstly I would just like to say that I really support the findings of the interim report, and in particular, the finding that the agreement is not fit for purpose as well as the urgent priority to address psychosocial support. Really want to cover two things today, which are in my submission. The first one is to talk about, like, a human rights focus, and the second one is just to talk briefly about how to go about investing in psychosocial support.

So to talk about the human rights focus, I think it's important because there has been a lack of progress in some areas of mental health ever since the Richmond Report,

and I think it reflects, kind of, in general health, there's sort of a detachment that happens between the illness and the person, and I think having a human rights focus would help put those things together a bit better. And I would say, in mental health, we possibly do better than other areas of health in that anyway because at least we talk about it and do some things, but I think we've got a long way to go in terms of that.

And I think the – that one of the expressions of this that has kind of got lost, perhaps, is quite a while ago the National Mental Health Commission thought about this and talked about the goals of mental health support as supporting someone to live a contributing life, and by that, people were talking about having meaningful things to do, having good relationships and so on, and I feel like that's not the easiest thing in the world to get a health system to focus on, but it's really important in terms of success of a mental health system to be supporting people to achieve in those other areas of their life and not just focus squarely on the illness. And that's one of the reasons why the psychosocial support is really important to making our mental health system more effective for people who need that.

And I would also say that, in my experience, sometimes when people with lived experience talk about what they want out of mental health, there's a fair proportion of it that doesn't get taken up because it tends to sit outside of that narrow band of an illness focus, and so having a human rights focus – or a human rights outcomes focus, for want of a better word, that drives mental health system reform and investment – I think it would make some of those conversations with lived experience reps more aligned to what we want to see happen.

And I think the World Health Organisation has shown great leadership internationally in terms of developing some really useful papers and tools to assist jurisdictions to become more human rights focused, and I guess when I looked at the summary of the interim report, I didn't really see a focus on human rights in there, but I do think that that could really help, particularly in places like where trying to get Commonwealth States and Territories to agree on directions, having a human rights focus to sort of give guidance to that would be really valuable. Not sure I can tell you how to do that, but I was hoping that .....

DR JACKSON: ..... sorry.

MR BUTTON: You can have a crack, Geoff.

DR JACKSON: Yes.

MR HARRIS: Well, I think it's – like, starting with that, like, to talk about those international conventions and agreeing that they should guide how mental health services and systems get developed. That would be a start, but one of the difficulties is often in mental health when – when we talk about human rights, the discussion goes to doing less bad things to people, so least restrictive treatment, for example, whereas I think in terms of system outcomes, it's actually being broader and – like,

the biggest loss, I think, in the human rights area would be that failure to support people to do well in their life and just focusing on a narrower band of work, if you like.

MR BUTTON: And certainly – I guess just building on those sorts of things, Geoff, and drawing from the experience you have in your membership in South Australia as well, perhaps it's – it's how do we embed those human rights principles in the tools that are being used to determine commissioning of services, planning services, etcetera, as well that might actually influence how the system starts to shift.

MR HARRIS: Yes. I think – so I think investing in the psychosocial supports would go a long way to that because that's kind of what those services do. It's a bit like the glue that might make more narrow, more medically focused services be more effective if – if people get both in parallel and – but I think the – it is really difficult to shift the dial on service settings, and particularly the more crisis-focused they are and the more busy they are. Like, it's not – it's not like people are sitting around doing nothing. So it is difficult to bring it in, but at least having those aspirations around particularly, I think, the contributing life concept would be valuable as a – as – to give direction to how mental health services are delivered and what the aspirations are for the results of them.

I guess – so to change topic slightly, I think – so the second point I wanted to talk about was around how to deliver psychosocial supports. So we've done a bit of work with some local groups in two areas of South Australia and – like, I think the service design aspects of it are probably fairly – you know, they may be a bit more detailed than you really want in terms of the work that you're doing now, but one of the things that struck me was if that investment was focused on addressing all of the need – all of the unmet need that's identified in the reports, then you would get less risk of inadvertently excluding people to try to manage a scarce resource, and I think that's one of the reasons why mental health is a bit complex in terms of the services that are there at the moment, is there is a lot of I guess fear of promoting services for fear of being overwhelmed. So that would be one principle that I think is a standout for addressing unmet need.

Secondly, with workforce, obviously with a big investment in psychosocial support, I think there's a need to invest in workforce development, and particularly around lived experience workforce, and we do a fair bit of work on that in SA, and it's – there's work sort of with individuals around things like communities of practice to support people to maintain the principles of peer work, but also working with organisations to make sure that their systems and structures are appropriate for peer workers to do their jobs to the fullest extent. And then a third thing which I think relates to our previous discussion is, we would really like to see an investment in research capacity to work with the stakeholders around what are the things to measure around impact of psychosocial support services, and then using that – to use that to develop reports, talking with stakeholders about that, and using it for quality improvement in terms of the services, and we don't tend to do that very well, in my experience, but

that's – like, that's one of the things I think that – there's a lot we don't know in mental health about how to be effective.

And so investing in psychosocial supports, as well as investing in the evaluation of – not the evaluation, but investing in those systems to look at, you know, how do we go talking with people with lived experience around what the data means, and then using it to get better at it, I think would be helpful in terms of kind of understanding how to be more effective in those broader areas of human rights, and also I think some of those areas are quite difficult to shift the dial on, you know? Like housing, employment, and so on, but in health we rarely contribute with data to those discussions. So, yes, really, that's all I probably wanted to say in terms of opening statements, yes.

MR BUTTON: Okay. Thank you. I might step into some of the stuff you were just talking about then, particularly in relation to psychosocial support, what that might look like. Are there models of where it is or was working in South Australia that you can draw on to provide some examples of what do you think it might look like, so at least we can build around that, because certainly for us, we're – as it says in the interim report, we're suggesting that we do need to build the evidence base around a range of things.

MR HARRIS: Yes.

MR BUTTON: And certainly we want to make sure that there's transparency of reviews and evaluations, and those things are publicly available, when reviews and evaluations are done of initiatives in the agreement, and in the psychosocial support space. We would like to be able to say here is the evidence that suggests, we've already pointed out there's the 500,000 people that are missing out, but it will also be helpful to be able to point to things to be say these are the things that are working well, are well-accepted in the sector and community that can actually start to address the unmet needs approach that has already been, I guess, identified as well.

MR HARRIS: Yes. Look, I think there's other people probably better qualified than me to answer that question, but I think if you're looking at New South Wales, there's the HASI work, and in South Australia there's probably a couple of significant evaluations. One would be – and both independent done by Uni of New South Wales. So it's one which is IHBSS, the Intensive Home Based Support Service, there's another which was the evaluation of the IPRSS service, which is Individual Psychosocial Rehabilitation and Support Service, and I can send you links to those if that's useful, but they really – like, I think it's – in terms of delivering services, it's reasonably well-known that if you take a – like, a recovery approach to it, and you have trained staff, and you have policies that encourage recovery, rather than kind of a more conservative risk approach, like – then it's – the actual work is pretty well-defined, I think, in those terms, and that's where with the work that we did, talking to local groups, I think the referral pathways is a really important part of it.

Sorry. To go back a step. Like, I think that – so in South Australia, the – our Department of Health has recontracted probably 18 months ago now, March last year, the – all the psychosocial one-on-one services, and I think a lot of the elements of what they've put in their tenders are really relevant to what you would want to do in the future, you know, specifying organisational competency, specifying, like, appropriate qualifications, things like that, and pushing for an increase in the number of peer workers in services. So I think some of those things are pretty well done in the states, but the system design work is what we were looking at in our discussions with local people, and that's – and I think – like, an example that we proposed that happened in South Australia was, there was an urgent mental health care centre that was developed here, and essentially the process was to call for expression of interest, then select the preferred provider, and then do co-design work to get into the detail of how it should be delivered, and I think that's – that kind of approach could really work in psychosocial supports where, I think it's pretty easy to define the broad parameters of what the work is, and then working with local people around how you roll it out.

So an example would be that one of the areas we looked at, there were a lot of people who were born overseas in non-English speaking countries. And so if you're trying to deliver services in that environment, you would want to be doing it maybe differently to, say, the country area we looked at where, you know, had fairly significant regional identity and probably low numbers of people who were, you know, born overseas in non-English speaking countries. And so – yes.

So that – that's a kind of approach that I think would be pretty easy to do, and we also looked at referral pathways, and if you were looking at delivering to all of the demand that's there in those reports, then you want to have broad referral so that – you want people to come from GPs, from Commonwealth funded services, from State funded services, and it's more a – in some places it's more of trying to find those people and reach out to make sure you're getting the referrals from different population groups, rather than being worried about being overwhelmed by the demand, and we certainly found that GPs were really enthusiastic about this, and were very interested in a model where if you were to put, say, a peer worker in general practice as the link to psychosocial supports, they were highly supportive of that because they recognised that, you know, the biggest presentation is for people with mental health issues, and for people with severe mental health issues, or even moderate where they've got psychosocial needs, they really feel like they haven't got the tools to support those people as well as they would like.

MR BUTTON: Tell u a bit more about that, Geoff. Is that – why I ask is because it is again thinking about models of good practice where – and we certainly have seen a big emphasis on peer workers, and those with lived experience through this process

MR HARRIS: Yes.

MR BUTTON: - - - and the need for them to be very much front and centre in terms of the overall care and support model for - - -

MR HARRIS: Yes.

MR BUTTON: - - - people who are experiencing mental health and suicidality. So where there are some of those models that are working where lived experience, and working alongside clinicians, and they've got a good, I guess, operating rhythm in place that's supporting people to come through the process, they're the sorts of things that we do love to hear about. So tell us a bit more about those things.

MR HARRIS: So we didn't get into the detail of that kind of approach, but there is some research going on that Sharon Lawn is doing. Is she presenting to you that you know of?

MR HARRIS: Okay. Well, like, what I can do is I can send you her contact details, and she would be able to provide you with information about where the research is at. So she's researching in I think three or four locations in Australia, a model that's similar to that, like having a peer worker in general practice, and I think – like, there's issues with it in terms of it being kind of temporary or, you know, kind of one-off, and there being a – like, a timing issue with the research to try to get people in this – in a narrow window, but it's certainly not a – yes. So some work being done on how to do it in practice.

DR JACKSON: Yes.

MR HARRIS: But certainly when we talked to GPs, they were very interested in it, and I think that, like, really, the detail of it – it would be really good to do a pilot in a few places to just get the details sorted, but I think there's a high degree of openness to it, given the mutual need really, yes.

MR BUTTON: It's certainly good for us to know about it, and if there's research that you may have, or Sharon has got available - - -

MR HARRIS: Yes.

MR BUTTON: - - - certainly happy to receive that and consider that in the mix, because as you would also appreciate, one of the interim recommendations that we've put forward is around the stigma and discrimination reduction strategy, and if there are examples where you've got some of these models in practice that are working well to then do that exact thing, where it is about actually looking at supporting GPs and supporting clinicians to think differently, because they're

working alongside lived experienced people in their practice, then that would certainly help as well.

MR HARRIS: Yes, and I agree with that. It's – there's a lot of things to do, isn't there, in mental health, yes, but, like, we – yes. So we certainly found a high degree of interest in our consultations from GPs to really look at a model like that, and I think the – if that peer work in general practice is linked to a broader psychosocial support service, then it makes the role a lot easier, you know? You don't have to, like, negotiate it for each peer worker. It's more like an organisational negotiation with the general practice or the GPs to make it work, yes.

DR JACKSON: Yes. I was just going to ask around the outcome measurement question.

MR HARRIS: Yes.

DR JACKSON: Because one of the issues we sort of, I guess, generally grapple with in this space is more of – kind of – obviously we're having a lot of chats around productivity at the moment here at the commission, and we obviously measure that through GDP per hour worked, and it's an imperfect measure, but there's one measure we sort of all agree on, but that in some of the care sector, mental health in particular, those outcome measures aren't necessarily consistently applied, and is that something we should be thinking about in the next agreement, that we – that through co-design we have agreed outcome measures that we can then look at different services, different interventions or the need to be more tailored to specific interventions, it's not doing that high-level approach. Just what your views are and what you've seen in terms of evaluating whether these programs are working or not, or whether services – because obviously you can have a model that works in one location, but not another, or one service provider and not ..... and how we evaluate and monitor that.

MR HARRIS: Yes, that's where I think, like, there's still a lot to learn about that but, generally, like what I see in mental health is there was a lot of effort to try to get, you know, particular metrics measured and reported nationally. That infrastructure has kind of, like, been knocked around a bit through the National Cabinet process a few years ago, but I think in evaluations, there's a lot of – lot more light and shade around those things of, you know, what do people who receive the service think about it, what do family members think about it, and in terms of productivity, I think, you know, there's issues around more individuals being encouraged and supported to work, and certainly family members, like carers, can work more if they feel like they have less stress, or less of their time is going to support their loved ones.

So in terms of that investment that I was talking about around psychosocial support, absolutely. You would be looking for those kind of outcomes, and not just the more traditional mental health outcomes that we see currently reported, and a lot of the – I think also a lot of the information that's reported is kind of internal system dynamics, as opposed to, you know, real – like something that's closer to outcomes and, again,

that's where I think the human rights conventions would really help to guide the sort of scope of that, whereas at the moment there's a lot of risk that the scope narrows to, you know, particular parts of the system performing better, you know? Like in the States, it's emergency departments and hospital beds, like other things that the media reports on, they're probably the things that the public knows more about as well.

So it's really – like, there's a big risk that we go back to try to manage those things without necessarily delivering on those broader human rights outcomes of people leading good lives, you know? There's a lot of creative ways you can find to keep people out of hospital. Doesn't necessarily that they're going to be leading a better life. So – yes. So really would be keen to see a better approach to that, and the – like, for me, probably the best thing I've seen is the contributing life work from the National Mental Health Commission, because it genuinely was derived from lived experience thinking and voices, but it hasn't necessarily translated into, you know, any kind of outcomes framework or, you know – it has sort of remained a bit theoretical, really, and I don't think – haven't looked recently, but I don't think we've shifted the dial in terms of employment rates for people with severe mental illness and so on.

So – and I don't think these things are easy. And so having sustained focus on them would be really helpful, and I think even in, you know, say the psychosocial supports we have at the moment, you know, it would be really valuable to be interrogating them around those kind of outcomes, and to be looking at ways to make those services more effective in those spaces, whereas I think probably there's a more reductionist approach that could be the one that could be more of a default pathway, if you like, which is as long as someone is, you know, out of the hospital system, or not inconveniently somewhere else in the health system, then that's a good outcome, whereas, you know, a human rights approach would look at more than just that.

MR BUTTON: Just building on that, I'm conscious of the time, Geoff, but building on that one, one of the things we talk about in the report is the transparency of information and data, and the proposal around, I guess, the potential of the dashboard, if you like, a public reporting dashboard of information, so it then becomes public-facing in respect of performance. Whilst there is a bit of work to do in relation to sorting out measures and indicators, and what that might look like, your thoughts on making data and information publicly available about the improvements in the system?

MR HARRIS: Yes. Look, I strongly support that. Probably the thing that's – that I think is missing is useful data for people with lived experience to look at and discuss, you know, like this. So a lot of the data that's around isn't really outcomes data or even close; it's not even impacts data really, and so the quality of that data's really important, and that engagement with the relevant stakeholders to then improve our performance is kind of what we need, and that's really difficult to do given how much the – I guess the public debate around mental health; it kind of switches between – so in a state setting, it's emergency departments and hospitals and adverse outcomes, and in a – in, say, a Commonwealth space, it's access to things like

psychologists and, you know, like the frustrations that people have. if you sort of pay attention to those, they don't necessarily deliver you a better system in that holistic sense, so that's probably the caution I'd have around that. It really depends on what the data is, how useful it is, to sort of drive a better system and better investments.

MR BUTTON: Thank you. I really appreciate that. Now, we are at time, Geoff. I really appreciate your appearing today, and certainly welcome you to send some of those – some of those additional pieces through when you do get a chance, because that would be great for us to consider in the mix as part of building the evidence about where to go next as well. So thank you for appearing today, and I hope you have a nice day.

MR HARRIS: Thank you. Really appreciate the opportunity.

DR JACKSON: Yes. Thank you very much for your time, and all your work. Thank you.

MR HARRIS: Thanks.

MR BUTTON: And so our next participant is Catherine Joseph from the Mental Health Carers Australia. I did see Catherine – and five others. Okay. I'll let Catherine do the introductions, then, when she comes on.

MS D. BACKMAN-HOYLE: Hello. I'm wondering if you can hear me. I'm here with Catherine.

MR BUTTON: And .....

MS BACKMAN-HOYLE: Yes. Great. Excellent. Thank you. And I've got the privilege of doing the opening statement today.

MR BUTTON: Excellent.

MR BUTTON: We can now see you, which is great.

MS BACKMAN-HOYLE: The team is there as well. So, look, thank you so, so much, and .....

MR BUTTON: Can I interrupt?

MS BACKMAN-HOYLE: Yes, of course.

MR BUTTON: Just so, at least, for the transcript, what we want to make sure that everyone does at the beginning of their sessions is to provide their name, their title, etcetera, so, at least, within the transcript, we can identify who's saying what in the process, and that would be great.

MS BACKMAN-HOYLE: Not a problem, not a problem. So, thank you, Commissioners Button and Jackson for the opportunity to appear today. My name is De Backman-Hoyle, and I have the privilege to present this opening statement on behalf of Mental Health Carers Australia. I am the national manager of community engagement, and it is my pleasure to introduce our other team members with you here today, and they'll be joining in on the conversation when we have that more informal Q and A part of our session.

So it was the 25th of June this year, at the Mental Health Australia Policy Day, and Commissioner Jackson, where you described the current agreement as "a bunch of announcements waiting for a strategy". Let me fact-check that. Would that be correct? We have ears everywhere, and but we want to say that we couldn't agree more. So mental health families, carers and kin, feel this exact sentiment every single day, and we see a patchwork of siloed services, and as we experience responsibilities bestowed on others that are simply – they're unclear to us, and, as well as that, we're witnessing too many people fall through the cracks.

So, to start with, we want to suggest that there is an opportunity for the next agreement to be different. And I want to come from the perspective, and some of the things that Geoff said – I got to sort of listen in and I've been around probably nearly as long as Geoff – but I guess one of the things is to really start from the point of view of the principles of relational support, and when we talk about relational support, be more specific and say "in places and spaces" where the best opportunities exist for recovery for not just the person recovering, but for the collective of their family, friends and kin; their chosen support people.

So we know that recovery happens within the domain of families within the reality of relationships, and also inside broad community settings. We've done so much work and reflection on models of care, and we've been gifted to understand and acknowledge the wisdom from some of the older surviving cultures in the world, such as our Aboriginal and Torres Strait Island peoples, and how they have gracefully enough reminded us and taught us that social and emotional wellbeing is a collective human experience, not just for their culture, but could be for ours as well.

So we want to make the point really clearly that we believe that we heal and thrive together, and never in isolation. So with the next agreement we must also recognise that mental health carers need to be treated as equal partners, and yet also recognised as having distinct needs of their own, and this can only be done with dedicated and ongoing state and territory resourcing of family carer peak bodies in every jurisdiction, and, sadly, this is not the case as we speak now, and I know that you understand that, that there's gaps and there's no state or territory carer peaks in some locations, and Geoff has just brought that home beautifully: South Australia one of those deserts that we don't have a dedicated peak body for mental health families.

So we need to ensure that embedding carer-lived experience in all of the governance activities as well as ensuring that mental health carers' perspectives and needs shape decisions, and that means at every level of government. So we're asking you, if you could, to mandate funded supports for families and carers in the agreement and in the bilaterals, and we want to sort of be a bit cheeky and suggest to you that clarity of understanding of our needs is never going to be enough, and that unless we have supports for families and carers that are explicitly written in, baked in, and resourced adequately, support for carers will sit as a discretionary option, and very likely to be very underdelivered.

So these aren't abstract asks. In fact, for you, they're solutions; they're answers to reduce the lived experience of pain and distress for so many families, and, at this moment, I just want to stop here and just let you know that the team that you see, we're all in – we've got purple behind us, so you will probably recognise all of us, but our mental health carer team here – Mental Health Carers Australia team here – we're not just advocates and people working in the profession of a peak body in our advocacy roles, and something really important to understand about us is that the majority of us are currently living or have had lived experiences as mental health carers; this is our day-to-day reality; this is our world, and we are people that describe ourselves as every other person would in relational constructs, such as brothers or sisters.

You know, we have someone on our team who is a sister that's put aside their own career and education to support a loved one who is a sibling in crisis, and we have people that have had to take the role of becoming translators for multicultural communities, and translators between generations that still haven't learnt to speak freely about mental health distress challenges, etcetera. I will speak for myself: I'm an aging parent who is draining my retirement savings to secure emergency housing for adult children who are needing housing, when the system fails to be able to provide housing, for example.

We have a grandparent in our team who's giving up her fantasy of being a silver nomad, and having that lifestyle, to raise another generation of youth in crisis and mental health distress. So, you know, it would be really great to tell you that these staff stories are rare stories, but they're not rare stories, sadly, and they are everyday Australian stories shared at kitchen tables in thousands of households every day of the week.

So for us, we know that we have this really big responsibility as the national carer peak body for mental health carers, because we know that there are 900,000 family members in Australia who identify as carers or kin, who, frankly speaking, are the glue and sometimes the sticky tape that is holding the Australian mental health system together. And we go back to the Productivity Commission's own inquiry, estimating that supporting mental health carers adequately would cost only $153 million per year, but would deliver savings on the system for the system of up to $318 million a year. Now, that's not a bad bet when it comes to a return on investment dollar for dollar, and yet in reality, the sad part about it is that governments aren't aware that what's also taking place at the same time is that we are extracting over $20 billion worth of unpaid care each year from Australian families, and it's not a gift that people want to give, it's a gift that they have to give.

And this is a true cost to every Australian family that's doing this, and it's a saving to other Australian taxpayers who don't actually need the support of the mental health system. Then we look at the individual family realities, where 40 per cent of primary carers provide the equivalent of a full time worker. Now, they do that without any wages to subsidise. That includes superannuation, thinking about their needs ahead, any safety nets in place such as WorkCover protections, or any of the benefits such as employee assistance programs. There's none of that. They're just out in the wild doing what they're doing, and a system that relies, even if it sadly is not understood as exploitation, is experienced as exploitation, rather than an investment, cannot and won't deliver the quality outcomes that our communities need.

So, Commissioners, I guess what we're trying to do for you today is put the evidence that's already on the table back in front of you, that families and carers are the largest mental health service in this country at the moment. They're plugging gaps left by the fragmented system, and it's not tenable to keep carrying this system, and we welcome the interim report acknowledgement of families and carers, and its recognition, and that lived experience peak should be embedded in government – in governance. We say thank you. That's incredibly good that that is understood and known, but recognition without action is not going to be enough, and being able to influence without structural power is just survival on borrowed time.

So families and carers remain left out of, currently, commissioning decisions, left out of data collection, research, and that for them means that their supports will be inconsistent and often grossly underfunded across every single jurisdiction. And what we're also experiencing out here is that what used to be available once upon a time in the means of meaningful psychosocial services, just seem to be continuing to be vanishing in front of our eyes, and cracks between different governments and service providers. And so that's coming back to a really scary time, where for so many thousands of families, what is still there is emergency department and clinical care, priceless clinical care, not psychosocial support in a community setting, and this is just leading to more tragedy, it's leading to more pain and leading to more lost lives, and we know that, you know, for every suicide prevention campaign that spends thousands, and thousands, and thousands of dollars, if the system is in place, the campaign cannot save people. It just can't save people.

So we know suicide prevention in the world that we live in happens in the moments in the households, for people supporting people, not in activities such as campaigns. So as well as the human costs, we've got to think about the future cost to the public purse. And so without urgent reform, families are going to go on bearing the cost of system failure, and that includes their health, their finances and their quality of life for their future. And so we are, without sounding particularly grovelly, begging and calling for transformational change. We don't need patching or patchwork activities, we don't need another layer of pilot programs, please, or gateway aspirational ideology. We need a rebalanced system grounded in relational recovery.

And so we think of things like open dialogue that has got such incredible results. We think about concrete examples such as the Victorian Connect Centre, you know, where people and families can show up and get support. And so we want to think about services that work with families, think about families, think about the relational outcomes that they're improving, not just for an individual, but for those that sit around side of them, and we want these family members to return to the opportunity to experience full citizenship in their own community. So the next agreement has to be more than a tidy-up. It's a chance to deliver on a system that's relational, integrated and sustainable, and we are speaking on behalf of that 900,000 Australians that need the change within their family, and their communities, and they need it, they deserve it, and they've been waiting for it.

So that's my word count for my part of this, and I would like to open this up for my team and my colleagues to participate in the questions you may have on the result of that, because, Catherine, who you mentioned in the beginning, is the subject matter expert on our behalf in this, as well as others. So, team, it might be a really good thing if you just quickly introduce yourself to the commissioners, please.

MS JOSEPH: Catherine Joseph, senior policy and project officer.

MS DOBSON: Annabel Dobson. I'm the manager of policy and advocacy, and thank you, De. You couldn't have expressed that better. Really, congratulations on putting forward a very strong message, and we strongly support what you said. Thank you.

MS BUTTERWORTH: Rahnee Butterworth, senior project – policy and project officer.

MS ANDERSON: I'm Wendy Anderson. I'm the manager of governments, and grandparent carer.

MS McNAMARA: And I'm Rachel McNamara, the digital communications lead.

MR BUTTON: Thanks for the statement, and thanks for – everyone for joining us. I'm going to go into some questions, and I'm going to focus on some of the things that you mentioned in your submission, because there are three very interesting – not to say that they're not all interesting, they are all interesting, but there are three

particular ones that I was going to focus on in terms of lines of questioning for today, for you guys to comment on. The first one is around the distinct schedule of saying – recommending that there's an inclusion of a distinct schedule for families, carers and kin outcomes in the next strategy, and make sure there's some measurable actions and accountability mechanisms. I would like to I guess get some – get your thoughts and ideas on that, and why it's necessary and what would that look like. Go Catherine.

MS JOSEPH: I will take – yes, I will take that one. Yes. So I guess our members have all – and MHCA historically has called for a separate strategy entirely, so a mental health carer's strategy, because, historically, like, we have De, who's on the National Carer Strategy working groups, and we've seen the National Carer Strategy – they don't include the distinct needs of mental health carers, they don't consider them, they don't – so – and it – broader mental health strategies are very focused on that individualistic recovery, that consumer-centric model that, as De mentioned, is just not going to work for the 900,000 Australians living this day-to-day life.

So we are asking for a separate schedule at the very least. If we're not going to get a – because, yes, we've got the National Carer Strategy, we have a mental health strategy coming up, that's a lot of strategies to work with. It makes a lot of sense that the next mental health strategy has a separate schedule with specific outcomes, specific goals for carers, because if they don't have that, it's just going to be another thing that's just swept under the rug, "You know, the consumer is okay, so, therefore, the carer, the family is okay". It's the way that we've talked about mental health carers for so long, and I think that needs to change with the strategy.

DR JACKSON: The thing around a schedule – and this is getting a bit bureaucratic, but maybe where you were going to go - - -

MR BUTTON: Yes.

DR JACKSON: - - - is what it requires, effectively, is its own governance framework to sit above it in terms of accountability. And so I guess ..... fully on board in terms of needing to look at carers in the next agreement, but do you think that– number 1, is there that governance framework that could oversee it currently in the mental health space in terms of carers and, if not, is that something that you see as being needed and necessary in this space, or is really what you're saying is at the moment, the previous agreement, as I think we highlight in the interim report, doesn't address these issues at all but, really, they have to be part of the next agreement. Does that make sense? It's a ..... we're conscious in other spaces as well that this governance issue is really – and it's getting quite technical and quite bureaucratic, and possibly, if anybody is on the line, going to put people to sleep, but that's one of the things we're just thinking through in terms of the recommendations.

MR BUTTON: And it may be that's sort of a bit of a focus to say, let's ensure that there is a – there's specific actions that sit inside the strategy, because what we've described is ..... see the interim report, we're saying we need a long-term strategy, which would then inform the next five-year agreement. And so what you're suggesting is that this focus is in that long-term strategy, so that it then has a cascading effect down to the next five-year agreement.

MS JOSEPH: Yes, no, we agree that there's definitely that bureaucratic hurdle if there is that schedule. So – and no, I appreciate also the interim report that we talk about including lived experience, including the peaks in those governance agreements, and I'm sure that is something that if it came down to it, we could talk through, but it is, again, a hurdle, I appreciate, but I also agree, Commissioner Button, the – that there needs to be separate actions, there needs to be a clear focus, and that can be done in the strategy in that way, as you mentioned. I'm also opening up to the team to see if they have any other thoughts on that kind of arrangement. No thoughts.

MS BACKMAN-HOYLE: Sorry, I'm – I just was aware that my voice has probably used its quota. No, I would agree with you. I think that there is the complexity and the difficulty. It's just really carving out the uniqueness and the space that's important within the methodology and the tools that you use.

DR JACKSON: I am aware of the work around the scope and practice that's currently around the peer workforce that's occurring, is the carer peer workforce feeding into that part of the process, and is that something that's working well, or – because I note, sorry, your point 3 about – no, point 2, sorry, supporting the expansion of the carer peer workforce, and I would have thought that ensuring that the scope of practice it has developed encompass the carer peer workforce. Have I just opened a can of worms that I don't know? Like .....

MS BACKMAN-HOYLE: No, no, you – no, you haven't. It's a really interesting thing. From the carer peer workforce - and please, team, if I'm using the words, just cut me off and you speak, okay? But I think what has happened is that as the carer peer workforce has evolved over, in some jurisdictions, up to 20 plus years, it has been around for a while, in some less time, it's patchy, it's still very patchy. It's very much around are they located and sitting within health service systems, or are they located and sitting within the community sector systems as well? And so we don't have a very clear picture at this stage about numbers, about employment status of any of these cohorts of people, and is it required, is it needed? Yes, it is for, I guess, a service support system, but the advocacy space and the peer workforce space haven't got their voices connected yet. That has still got to happen.

MR BUTTON: All right. A couple of other quick ones before we run out of time. The – you've recommended a review of the National Mental Health Service Planning Framework, and in partnership with lived experience peaks. Can you explain why we need to review the service planning framework? We're suggesting obviously as part of this process that we need to have some consistent use of applications of tools. We've heard a few

from others yesterday in relation to focusing on reviewing in the framework, but I wanted to hear your I guess argument in respect of why we need to review the framework as well.

MS JOSEPH: So initially I guess we would say that we don't actually have any oversight of the framework, because we're not a commissioning body, and we only have seen the taxonomy that's publicly available. It is very antiquated. There's this, "Families just need peer groups, they need one-on-one counselling". That's like – it's very simplistic in that way, and we also take to the point, because we read the interim report, and the point of the PHN collaborative mentioning that it is very much focused on primary clinical kind of care. It's more suited to that application. If PHNs are going to use it for psychosocial commissioning, as has been recommended in the interim, we don't think it's suitable without us, at least the lived experience peaks, reviewing that framework. It's – yes, that's where we're coming from there.

MR BUTTON: Okay. No, no, that made sense, but certainly wanting to be able to get that out so it's said on public record around what that – why we need to look at those things as well. So thanks, Catherine.

DR JACKSON: And we certainly heard that ..... as well.

MR BUTTON: Yes.

DR JACKSON: So thank you.

MR BUTTON: And the last one from me is in relation to – your recommendations around a carer data upgrade, and that being led by the Mental Health Commission with AIHW to look at refreshing and establishing this disaggregated data. What would that look like, and why would we need to do that? And I might be asking you questions that you've already answered in your submission, but the reason I'm doing that, Catherine, is I want to make sure that we get these on public record in the hearings as to why we need to focus on these things as well.

MS JOSEPH: Yes. Sorry, I just wanted to see if the team wanted to answer, but I'm happy to take that one too. The main kind of point we're coming from here is that if you don't have any way to even know that amount of carers that we have here, how are you going to support them? How are you going to even know what they need? We learn of it anecdotally, because we have connections, and we talk to our families, our carers, but how is the system going to improve if we don't even ask the people that are supporting the system what they need, and what – how things are going. So we know we have the care survey at the moment. That's – and it's – and we've got some public reporting on it in South Australia and New South Wales, and that's – but that really is a service satisfaction survey.

That's not really a, you know, "How is this impacting you? How is – what can be done to improve your recovery?" All of those questions we don't see in that survey.

We also have data that even the Productivity Commission's inquiry in 2020, was using a 2007 National Mental Health and Wellbeing survey data, because we just don't ask questions anymore about the impact of caring. It's only really available through advocacy agencies like ourselves, or we had Mind Australia doing a survey in 2015, we also have Carers Australia that does their own variety of a survey. Again, we come back to this point where if we don't actually have the tools, or the mechanisms to find out who we're representing, or find out about their needs, how are we going to improve the system?

MR BUTTON: And taking a step on from that, one thing that we're also recommending in our process is around publicly available data, and the – I guess the notion of a public dashboard to report on data, so that we – it can inform the public about how the system is improving as well. I wanted to get your thoughts on that.

MS JOSEPH: Yes, we would again support that completely. We love data transparency and accountability. Who doesn't? But the point again would be, we don't actually have those sources, we don't have the metrics, the measurement tools, other than the CES, and then a 2007 National Mental Health and Wellbeing survey, and some of the SDAC. We don't have a lot of tools that will capture the data that will be on this public dashboard. So there is something about developing the measurement tools, or using tools that do capture what we need to capture, and having that publicly accessible but, yes, the dashboard is a great thing, particularly for regional planning. We want to know what's – what was behind the decisions that were made with commissioning, particularly. So yes, no, we agree, I think.

MR BUTTON: Okay. We're conscious of time, and before we finish up, I want to make sure that we give the opportunity for the rest of the crew to throw anything else into the mix for us to consider, before we close off this session.

MS DOBSON: No, we're good, thank you. I'm good.

MS BACKMAN-HOYLE: Can we ask, if we do think of something afterwards, that we can send through - - -

MR BUTTON: We are happy for you to to send - - -

MS BACKMAN-HOYLE: - - - to you - - -

MR BUTTON: - - - additional information.

MS BACKMAN-HOYLE: That would be great. Great. Thank you.

MR BUTTON: ..... No issues with that at all.

MS BACKMAN-HOYLE: Great. Thank you.

MS JOSEPH: Thank you.

DR JACKSON: Thank you all for your work as well. Thank you.

MS BACKMAN-HOYLE: Okay. Thank you both. Bye.

MS JOSEPH: Thank you.

MR BUTTON: All right. Next ..... it will be from the Brisbane North PHN, and Libby Dunstan is going to join us.

MR BUTTON: Thanks for joining us this afternoon.

MS DUNSTAN: Yes. Thanks very much for having us. So obviously I know you very well, Commissioner Button, so I am - - -

MR BUTTON: Selwyn's okay .....

MS DUNSTAN: Can I call you Selwyn? All right. Great. Good. That's going to make me feel much more comfortable. So I'm obviously Libby Dunstan. I'm CEO here at Brisbane North Primary Health Network and, Caroline, do you want to introduce yourself?

MS C. RADOWSKI: Yes, yes, I'm Caroline Radowski. I'm the executive manager for mental health and wellbeing here at Brisbane North PHN.

MS DUNSTAN: So, yes. So we're – really – it's really great to be here. Thank you for having us. I guess I'm assuming that you want us to just to make a couple of just opening comments, and we will try and keep that very brief, because I think we would much prefer to have a bit of a discussion. So obviously, you know, really welcome the interim report that the Productivity Commission handed down, and had a lot of really I guess fantastic insights and observations that, here at Brisbane North Primary Health Network, we would fully support and agree with. I think what we probably thought we might focus mainly on today is, you know, specifically the – I guess the way a future agreement could enable, you know, I guess some of the regional kind of primary health care focused work that that we do as a PHN, but probably more so than that.

It's really that one health system approach that we try to take with Metro North Health, which is our hospital and health service, that's Queensland language, obviously, but other stakeholders and partners in our region, to understand how we I guess are approaching mental health and wellbeing in our region, but then using commissioning practices to address those gaps. So I think the significant failing of the current agreement for us at the moment has been just that lack of – you know, the – I guess the enabling infrastructure around, you know, the governance in particular. So not only just that – I guess the national level and then sort of bilaterally, but then even sort of just at a regional level really.

The work that we've done around regional planning and sort of co-commissioning, and working with our partners has been because we believe in it, rather than it being, you know, what we're required to do, although we are required obviously to undertake a regional plan. So we think there's a lot of power in, you know, the regional planning processes that PHNs actually are undertaking, because they should be inclusive of all parties to that, including, I guess, our lived and living experience community, and so that, really, then, when we are sort of commissioning sort of solutions that that's in accordance with what's needed in a particular community, so we'd like to see that sort of built on as well.

I think we'd like to see, you know, I think, the agreement enabling sort of a more responsive system to the emerging sort of needs, so I think, now, the data is pretty clear that, you know, the impact and prevalence of mental health conditions, not only in our region, but across the country, are not overly improving. You know, we're seeing some really, I guess, concerning, I guess, increases in prevalence, particularly in sort of priority population groups as well.

So, you know, I think we really need to be thinking about what sort of funding models are actually going to enable us to respond to those emerging needs, and I think the other thing that we wanted to talk a little bit about is that whole-of-lifespan approach, and, you know, I think some – a lot of, I guess, in my experience, being really forced to focus on sort of clinical services, but what people with lived and living experience and consumers in our region tell us is, "Yes, the clinical services are really important, but, actually, the psychosocial supports and the connection to community, and the sort of that whole social determinant sort of approach is actually equally important," and, in our experience with our integrated mental health hubs, the psychosocial supports are almost more important than the clinical support. So, you know, we really think that there's important considerations to think about in that as well.

Really liked seeing, I guess, you call out the importance of having some specific focus around suicide prevention. I mean, that's certainly an area of growing concern in our region, particularly, again, for some of our priority population groups. We'd like to see more work in that early intervention space, so we've been doing some work, and the Commission's report talks about safe spaces, so we've commissioned for safe spaces in this region, which is responding to people in distress. Again, it's a non-clinical service; it's peer-worker led, and the outcomes are really significant in terms of the impact that you can have on people's lives, and it's not actually an overly expensive model, but it's very difficult to sustain those sort of models moving forward.

I think the perhaps the last thing I might just add at this point in time, and, like, I've touched on it already, is really about the importance of the psychosocial supports, and, I think, you know, you'd be aware of that unmet need report and how many people are living in our community with their needs not met, and so, really, I think, from our perspective, when we talk to providers in our region, we – you know, we see that the PHNs could play a significant role in supporting, I guess, the

psychosocial supports that are needed in our community. So we're really looking forward to, I guess, seeing how that progresses, but it really needs to sit within an umbrella of what are we trying to achieve? What outcomes do want to actually develop, and then how do we support sort of or enable that response in a way that we don't have at the moment? So I might stop there, and perhaps there might be things that I've said that you want to pick up on or maybe have a bit of a discussion about.

MR BUTTON: I was going to ..... or is there anything you want to focus on?

DR JACKSON: Yes. Look, I think before we perhaps go forward – and we'd like to maybe discuss the alcohol and other drugs schedule too - - -

MS RADOWSKI: Yes.

DR JACKSON: - - - but we can deal with that maybe next bit. I notice our fellow Commissioner is on – I'm sorry to call you out – Alison [Roberts], who – and, obviously, we're telling – we're doing work more broadly, and it interplays with this inquiry as well, around that co-commissioning. We've obviously made recommendations around that in the interim report, but we are hearing that, potentially, the existing mechanisms and the – or that are in place in terms of PHNs might not be suitable from the psychosocial supports, and there's a potential that need to do further work with people with lived experience if we're looking at expanding that role. Is that something, well, that you've done, potentially, in Brisbane or is it something that you can see that there were clear – a need for a different approach as opposed to, I guess, the co-commissioning would be more clinical services, but the psychosocial does need a different approach?

MS DUNSTAN: Yes. I mean, Caroline might want to add to this a little bit, but, I mean, I guess the – you know, where I would start is by saying I think there's certainly capacity, at least in our experience, that we can build upon. So whilst we have a bit of psychosocial sort of money, that's almost in my mind the most critical funding that we hold, because it's actually what the community is telling us that they need. So we've taken a bit of pooled funding approach. I think, really, if PHNs were going to play a role in that sort of psychosocial space, I think we would have to have a really frank conversation about what those requirements actually are of PHNs, to undertake that appropriately, and how we give confidence I guess to the people that are at the end of that, that decisions are going to be made, you know, with a level of, you know, rigour, integrity, but also transparency as well, and responsive to – so, really, that responsiveness to people with lived and living experience is going to be critical, but do you want to add to that, Caroline?

MS RADOWSKI: Yes, I guess – and this is for Brisbane North in particular. The way that we have applied that psychosocial money has been, you know, in co-design and in – I guess, in tandem with lived and lived experience, which is why we have structured the funding as it has been, because we've heard from the community and other lived and living experience people that one of the hardest things for them is, essentially, access. You know, how do you access those different points of service

that are in community-based organisations, and how do you build the trust with those organisations?

And this approach – how we've done it is we've connected the funding to our Medicare Mental Health Centres, we also have some of the money supporting some of the peer work models out there, and it enables that flexibility so that people can engage with clinical services, or work with the NDIS, whoever that pathway has been, and some of the way that that was structured was actually founded from the Partners in Recovery program. So we've taken elements of best practice, and that's how we've come up with the modelling that we have. So I think the model that we have here – and it has been evaluated with our hubs – that it actually does work very well. We get good engagement.

In fact, we get a lot more engagement in our psychosocial service models, because we have done that co-design, and we continue to, I guess, evaluate and work with the people that are accessing those services, and the organisations do as well. So we have some foundational evidence on how that does work, but it's not, I guess, applied the same everywhere you go, because each region works with that funding differently. So I guess there's probably some further work to do where some areas, I guess, you know, might feel that there might be some changes that can be done there, but certainly for our region, we've had really positive feedback around how we structured that funding.

MS DUNSTAN: I think the key for me is about – is kind of what you said there, Caroline, is, you know, being inclusive, being responsive and being community-driven. So I think if you take some of those sort of foundational principles in your commissioning approaches, then in a lot of ways that's kind of what drives, but I think the other thing that – for us is really a very strong focus of – on access and equity as well. So really about not a one size fits all sort of approach, but really how do you meet the needs of a range of different people in your community, according to, you know, a whole range of factors, and all the intersectionality that kind of goes with that as well. So, you know, I think from our perspective, we feel that we've got some good foundations to build upon, but we recognise that, you know, that I think from a PHN perspective, having that trust and engagement with the lived and living experience community would be a critical success factor to delivering, in that regard.

DR JACKSON: Thank you. Did you want - - -

MR BUTTON: Yes. ..... I'm going to take it a different tack here, Libby, and if we take a step back from when PHNs first started, and money was rolled out in the sense of saying, "Here's what you've got to do in terms of commissioning services", etcetera, thinking about the capability requirements that were needed in a PHN to successfully start that process, and knowing where you guys are now, and the journey, what are the elements – what are those capability elements that you think need to be put in place, or should have been put in place in the first instance, that you've had to sort of grow and develop over time?

MS DUNSTAN: It's a really, really good question, Selwyn, because I think as you rightly said, when PHNs first were established, we had to sort of develop significant capability around all aspects of the commissioning cycle. And so I think, in essence, we had to also almost articulate and communicate what that commissioning cycle sort of entailed. So, you know – so from my perspective, I think some of the challenges that PHNs have with the way that funding is delivered to us, and I guess the expectations on us is, how you do co-design really well, because that's the foundational, I guess, piece, is actually understanding the needs within the – sort of that community.

You know, speaking to, you know, consumer and community members, speaking to providers, speaking to people in that region to say, "What does this look like, and how do you actually …" – so that co-design expertise – and some of the challenge that we've got is when things come down the line to us, we often don't get enough time to do adequate co-design. And I think in our experience, when do you do co-design well – so if I think about those integrated mental health hubs, the safe spaces, we've done co-design over a six to 12-month period. So when you are deeply listening and you understand, then you make good commissioning decisions.

So I think, you know, I would like to see, I guess, recognition of that really important understanding of sort of co-design. I think that sort of the – you know, the data and analytics side of things. So, you know, I – you know, what's – and it's qualitative and quantitative data. So what – you know, what does the data tell us about prevalence, uptake, services, needs, you know, all of those things, but you've got to overlay that with the – that's the – you've got to overtake – lay it with the qualitative data and the voices, particularly in the services that we're discussing today about, you know, your people of lived and living experience. That takes time as well, but also being able to take data and turn it into insight.

So I think where we've built our capability as well is, that it is about evaluating for impact. So if we are going to commission a service, we want to know, you know, that it's making a difference, and that the impact is worth the – sorry, I shouldn't say worth the investment. That's not what I mean, but the impact is it's value for money, right? So – because if it's not working, then you need to change and do something a bit different, but I think from our perspective, those key capabilities of, you know, understanding need, you know, how you co-design over an appropriate timeframe, how you partner with people, and I think people – what I hear from our providers is it is what people say that we do differently is that we partner with people to come to solutions, but to address problems as well.

So it's not a big stick approach where you're saying, you know, you're not meeting your KPIs. It's actually understanding what's happening in that particular service. So they're probably the key capabilities, Sel, that I would say that we would want to build – that we've got, but we would want to build upon, and I think it's part of the enabling environment to actually help us achieve what the agreement should be driving us towards.

MR BUTTON: No, that was good. And in the absence of that, I guess, coming – where does that come from? Does that come just internal, or - - -

MS DUNSTAN: Yes.

MR BUTTON: - - - is that just internal ..... or is that about networking across PHNs? What does that look like then in – is it a – is it just something that automatically augments in your own organisation, then you start to share it with others?

MS DUNSTAN: Yes. Look, I think – I mean, it's a little bit of both. I mean, I guess there's a level of core funding that PHNs get, and we've got to kind of do all of those things that we've described within that core funding, and I think that's a challenge. So I think we're – you know, I think, you know, we – I think, you know, all – I'm sure all PHNs have strengths and weaknesses. I mean, I think – and where you've got strengths, I think – I guess sharing those sort of approaches with your peers and your colleagues, but I guess where you're trying to learn as well. You try to look around and see who's – you know, who's doing things well, and how you might learn sort of from that.

So it's kind of, yes iterative in that regard. I guess it's probably more informal than formal, a lot of that sort of sharing as well, although, you know, I think, you know, particularly when it comes to things like our regional plans, our executives that – with responsibility for that are probably talking to each other all of the time, and you're then almost just improving in a step-wise way as you go along. So – but it's not formalised in any way. It's kind of done because we think it's a good idea, rather than it being enabled by any particular mechanism.

MR BUTTON: Okay.

DR JACKSON: Can you just talk a little bit about the shared governance arrangements that have been put in place? Sorry, this is really about us getting it on the public record, so that - - -

MS DUNSTAN: Yes.

DR JACKSON: Between your PHN and the – and your local health service.

MS DUNSTAN: Yes. So it was a little bit before my time, but in 2017, I think, you know, the then CEOs and board chairs of the PHN and the hospital and health service, I guess, sort of came together with a vision to think about, well, you know, how do we take a one-system approach, and move towards actually jointly trying to solve some of the problems, but no one organisation can solve on their own. So I think take my hat off to, I guess, the vision and leadership of those people at that time, but I guess what we have put in place is a joint governance arrangement. So we co-fund that. So the PHN and the HHS both put money on the table, and that enables, I guess, what I would call a small agile team that sits across both of our

organisations to work on shared priorities, but it is overseen by a joint governance mechanism at a board level.

So we have a joint board committee which is a formal subcommittee of both of our boards, so the hospital and health service, and the PHN. And so it has the two board chairs, two additional directors, the two – and the two CEOs, and that meets quarterly. And so the idea of that is at the highest level across our two organisations, is that we have a shared commitment to working together, and then I guess in the context of a commissioning, I guess, continuum, sometimes that's just about we're going to tell each other what we're doing, sometimes we will, I guess, share our approaches and we might say, "Well, you will be on our commissioning panels, and we will be on yours", and sometimes we will put funds together and we will say, "How are we actually going to solve a problem sort of jointly?"

And so all of that's sort of underpinned by, I guess, you know, a joint needs assessment, joint planning, joint priorities, reporting, and I guess a level of leadership that says this is how we do business in this region. And we can point to a range of initiatives, I guess, you know, cultural shifts in our organisations that actually has fully embedded that way in – of working that is – so it's not person-dependent now. So when a CEO or a chair moves on, I guess the foundations of shared governance are now so ingrained in our two organisations, that it doesn't make sense to do anything different.

DR JACKSON: And how important has that been? So, I mean, obviously there's cultural and there's capacity and capability, and you've mentioned co-design, but that joint governance, would it be possible to do what you've done, and it's often held up as an exemplar, as you're probably aware, comes up in many conversations across the board, you know, Brisbane North PHN. I thought it was just Sel, you know, blowing the trumpet of Queensland.

MR BUTTON: ..... because I'm a .....

DR JACKSON: Yes, because he's a local, but no - - -

MS DUNSTAN: He is a local.

DR JACKSON: How critical is that governance arrangement? Like, would it be possible without it, in your opinion?

MS DUNSTAN: I think – yes, I think it is a real critical enabler, because it actually enables you to do things differently, because you're coming up against two systems that work – that inherently haven't been built to work together. And so the way the funding flows, you know, the way you're reporting, like, it doesn't allow you easily to collaborate. And so what that joint governance does is actually help us challenge that status quo, and think about, well, you know, why do it that way? Is there a better way to do it? How do we jointly solve problems? How do we leverage each

other's strengths? Because we've got strengths, and the hospital and health service has strengths, but our joint priority is to support care closer to home.

So we want people to be well cared for in the community and, really, only interfacing with hospital services when it's necessary. So it is a real critical enabler. I think our vision in the longer-term would be to do a lot more co-commissioning. I mean, ideally, you do a plan around mental health, AOD and suicide prevention, and then you're commissioning against – or using that plan, rather than kind of what happens a little bit at the moment, which is siloed initiatives that are driven either sometimes nationally, but sometimes state, "We're going to fund this in this way", but actually that really takes the voices of community out of it in terms of what they need, and how you prioritise health resources in a – in an environment where there's no shortage of need, but sometimes you've got to think about how you make the best decisions to get the best sort of outcomes. So it's a critical enabler, but it could absolutely be built on more to support that co-commissioning agenda.

MR BUTTON: So two pieces for me, Libby, just building on that. What could change in the next agreement that supports more of that occurring? And also that I was going to get you to touch on it again for the public record, touch on how that model then also starts to connect with community control, and focusing on - - -

MS DUNSTAN: Yes.

MR BUTTON: - - - what happens for – you know, working with Aboriginal Torres-Strait Islander people as well.

MS DUNSTAN: Yes. So I will start with the first one there. So in terms of what needs to change, I might start, then I might see if you want to add something, Caroline, but - - -

MS RADOWSKI: Okay, yes.

MS DUNSTAN: But from my perspective, you know, I think what needs to change is a lot more of a fundamental recognition about the richness that is occurring with those – I guess with health needs assessments and joint regional plans, as really critical enablers to make good commissioning sort of decisions, and they kind of are floating in the system at the moment. They're not connected to any sort of State or national picture, and they're certainly not connected sort of to the governance sort of arrangements in place. They're kind of done, and I think depending on where you are, there's, I guess, varying levels of success. So guess some greater recognition about those sorts of roles.

For me, I think, you know, how we're actually utilising some of the funding in the system to better achieve outcomes at a regional basis. So there's – you know, there's not endless money, right? So how do we better use some of the resources or financial levers that we have in the system to do different models of care? I think that would be really interesting to have a bit of a conversation about. You know, I

think we've seen the better access evaluation, it's great, you know, for some people, but for marginalised populations, for people that aren't accessing services, they're probably missing out in that regard. So how do we use some of those levers in terms of the financial sort of incentives. Do you want to add anything, Caroline?

MS RADOWSKI: I do think the funding needs to be more – be able to be a bit more flexible in being more matched to the needs of the community, and the joint priorities, what we have, because at the moment, it's in line, so then you've got to commission against those and, yes, there will be elements of each of those lines throughout the community of need but, like, if you take something like mental health nursing, like, such a specific line, and maybe not necessary across everything, but you don't have any flexibility, is one example, to move that across to where you need to with the needs that are presenting. And again, we talked about the lifespan approach and suicide prevention. That's much broader than mental health some of the time.

So, you know, we need to talk about how to do we, in the agreements across the different funding that we have enabled some of the structures to allow it to be broader than the mental health, to really enable that – the national strategy, because we haven't got anything that can really address that need, apart from, again, a generalist suicide prevention funding line through the agreement. So there are some limitations to how we're funding the structure to really addressing those needs, and I guess the other thing is to enable a co-commissioning space, probably needs to be a little bit more, I guess, accountability on both sides on how that looks, because it's something that's – that we need to do and work towards, but not all the enablers are there in the space to do that, so, yes.

MS DUNSTAN: And in terms of the question about, I guess, working with the community control sector, so, I mean, certainly from our region, our local community control partner is the Institute for Urban Indigenous Health, and they are a critical partner, and I think what we've done differently here – I mean, we have spoken to IUIH about being part of that health alliance between Metro North and the PHN, and there are – and there's actually reasons why we haven't gone that way, but what we do do is ensure that there's formal mechanisms for IUIH to engage with that joint board committee. So usually on an annual basis, we will have a three-way conversation about those joint priorities, but I guess the other part of it is, as a PHN, you know, we recognise the particular burden that mental health, AOD and suicide prevention has in our First Nations community. And so when we're making commissioning decisions, we prioritise investment in that particular, I guess, priority population.

And so we've done some really innovative things. I think we're just about to launch the first headspace that's going to be co-branded between a community controlled health service and headspace National. So we're really excited about that, and whilst there are other community-controlled health services running headspaces, this one is actually for First Nations young people, their family and their kin, and will have a very distinct sort of service model. So I think it's about how we use the relationships

and the priorities to actually do things differently, and challenge the status quo. So – and I guess credit to headspace National for coming on that journey with us as well.

DR JACKSON: Quickly, before we have to go, because we're on a very tight time schedule, and there are people we can't see in this room who are going to give us the look of it's time to get on to the - - -

MS DUNSTAN: Wrap it up.

DR JACKSON: AOD's schedule.

MS DUNSTAN: Yes.

DR JACKSON: So if you guys had views on that.

MS DUNSTAN: Yes.

DR JACKSON: We've obviously asked for views in the interim report, and - - -

MS DUNSTAN: Yes.

DR JACKSON: - - - ..... viewpoint. And we may obviously have some follow-up as well.

MS DUNSTAN: Yes. Happy to provide any follow-up information. I guess probably in short, what – we would support, I guess, a focus on AOD as – it's kind of like what you've talked about with the social and emotional wellbeing, and the suicide prevention, you know, I guess, schedules or focus areas. We think that there should be a focus on AOD. You know, there's a need for – I guess how it plays out in the community is, you know, you treat people as a whole person. So there's, you know, that interplay between mental health and AOD issues is what happens. So we want to see, I guess, that actually integrated into this sort of an agreement, and I guess the same sort of level of accountability and governance as well, but did you want to add to that, Caroline, or - - -

MS RADOWSKI: Yes. Again with the AOD, it's around the funding as well, and its growth, and it hasn't really moved in a very long time. So that's one element that I keep hearing around – from the organisations, and it doesn't enable them to work in different ways, you know, in supporting the community as different substances come on the market, and also, you know, different communities access those as well. You need to be able to diversify the ways that you reach community, and also – again, on the prevention end, there's really not much there, if anything at all, that's funded - - -

DR JACKSON: Yes.

MS RADOWSKI: - - - in that prevention lens. So that's what I keep hearing in the intersection to the mental health. Again, that's a challenge which the agreement doesn't really enable .....

MS DUNSTAN: No. So I guess it's kind of why we think that should be, I guess, a clear focus as well, which I think is what you were asking for feedback on as well.

DR JACKSON: Okay.

MR BUTTON: Thank you. Really appreciate your time today, Libby and Caroline.

MS DUNSTAN: Yes.

MR BUTTON: You gave us plenty of food for thought, and plenty for us to think about, and we definitely will come back and have some more interactions about getting some extra information, as you've mentioned through the process. So thanks for today.

MS DUNSTAN: Yes.

MR BUTTON: I will see you both again soon.

MS DUNSTAN: Yes. Thank you very much for your time.

MS RADOWSKI: Thank you.

MS DUNSTAN: And talk later. Bye.

MS RADOWSKI: Bye.

DR JACKSON: Right. I think we have Equally Well Australia now. Russell Roberts, John Allan, Dave Peters and Catherine Lourey. Good afternoon, apologies for the short delay. Good afternoon.

MR BUTTON: Can you guys hear us?

PROF R. ROBERTS: Good afternoon. Yes. Thank you.

DR JACKSON: Thank you very much for joining us. I might ask if you can just start by introducing yourself and where you're from, and then invite you to provide an opening statement, and then we can go to more informal Q and A. Thank you. Good to see you again.

PROF ROBERTS: Dave, do you want to start?

MR D. PETERS: All right. Hi again. My name's Dave Peters. I am a consumer of mental health services, but lived and living experience and the co-chair of the Equally Well Alliance.

PROF ROBERTS: Cath. While Cath's coming on, you're on mute Cath, Russell Roberts from Charles Sturt Uni, and the national director of Equally Well,

DR JACKSON: Thanks, Russell. Seem to be having issues there. And John.

DR J. ALLEN: Hi. Yes. John Allen, I'm the co-chair of Equally Well, with Dave, who's the consumer co-chair, and I'm the professional co-chair. I'm an old psychiatrist, recently retired, I was a state-wide director in Queensland and many other things.

DR JACKSON: And, Catherine, have you managed to – no. I'm sorry.

MR BUTTON: Have a look up in the right at the microphone and see if you can unmute yourself, otherwise, maybe the Teams still has – there we go.

MS C. LOUREY: Apparently, the Teams always comes through, isn't it? Hello, and thank you. So I'm Catherine Lourey, and I'm a strategic adviser with Equally Well, and, prior to that, I'd been a mental health commissioner in New South Wales.

MS LOUREY: I think, Dave, you're kicking off.

MR PETERS: Thank you, very much. Look, I just wanted to open by saying, I guess, in an ideal world, I wouldn't be a consumer of mental health services and physical health-related service, I would just be a whole-body one person. You know, we do hear the term holistic care used quite a bit, but, unfortunately, the reality falls far short of that promise. If the system was working in my best interests, I wouldn't be treated by separate services for separate parts of my body, and separate services that don't talk or work well or collaboratively with one another, or, worse, sometimes being given conflicting advice about what is best for my whole-of-body health.

In an ideal world, myself and my carers would be active and supported in the roles that we participate in; we'd be working with clinicians and service-providers to produce a care plan for my ongoing treatment and recovery that has my voice, my needs and my wishes at the centre. In an Equally Well world, I wouldn't be facing 11 to 15 years less of a full life than most of the population, or that I had to sideline other priorities and my career and life choices as a result of having fallen through the gaping cracks in our health system.

In a fair and equal world, I wouldn't have experiences or I shouldn't have experiences where accessing health supports or professionals ends with me having my concerns dismissed or disregarded as a so-called symptom attributed to my

mental health, but, rather, as a legitimate question or concern in and of itself. Not being able to afford specialists or professionals due to fixed or limited income, you know, going to a specialist doctor and being told that my problem is of my own creation, and the solution is as simple as better managing my own situation instead of expecting someone else to fix it for me, being dismissed as an addict or having my concerns and questions dismissed. You know, one specialist prescribed a medication that saw me gaining almost 40 kilos in five months, and, upon review, dismissed my concern by saying that that was a known side-effect, as though I should have known that already, and I was quite outraged that I hadn't been informed of any risks or potential impacts of medication prior to beginning the medication.

In an ideal world, I would be able to self-advocate and have the support and understanding for me to make the choices that I need about my health, and to have the access and care that is accessible and understandable for other parts of the population. I'd love to see people getting health literacy and education about how their situation and health conditions can impact day-to-day life and create barriers to living a good life. In-depth discussion around treatments or support opportunities and support to link with and access supports for unmet needs, but also support to frame the actions that are within my sphere of influence, such as diet and exercise or maintaining access and participation in the community; maintaining employment or economic participation, and not letting the impact of my health conditions interrupt or prevent that participation.

It's really important to acknowledge and account for the impact of increased cognitive load. The assumption of power to implement change independent of support and a privilege, whether that be financial, education, housing, or secure housing. You know, the competence and space to challenge or question what you're told without being labelled as non-compliant or aggressive; the assumption of comprehension, whether that be due to language, cultural or educational barriers; and the impact of medication, whether that be cognitive, whether that be, you know, cognitive, sedation fatigue. So, I guess, in an ideal world, we'd be seeing my trajectory as someone who has health conditions pretty much the same as the rest of the population, but with the issues that I've discussed that's currently not happening to most people. Thank you.

PROF R. ROBERTS: Angela and Sel, would you like us to each read our statements or once – John, Cath and I have a short thing – a statement. So we can have a short statement and then questions, or do you want us to have three short statements and then have a general discussion. How would you like to format it?

DR JACKSON: I think if you guys go first, and then we'll know how much time we've got left would be the best to make sure that it's got it on the record. It's – okay. Thank you.

PROF ROBERTS: Okay. So, hopefully, Miriam has passed on to you and the advisers some more talking notes around this, so we'll just talk around those, and probably preface them, and Dave's statement, you know, when we look at the data

and by adopting the OECD definitions of "excess" and "potentially preventable deaths", Dave's situation, and worse, is the situation for 1700 people per month. These are excess and potentially preventable deaths per month in Australia; that's worse than the worst death rates through the middle of COVID. So people with mental illness are living through a COVID every month for every year for decades, and we're not doing anything about it.

So our statement is focussed on the urgency, but also that this – we can do something about this; the solution is at hand. For example, 42 per cent of all the premature deaths for people living with mental illness are cancer deaths. 12 months would make the difference between stage 1 cancer, curable, and stage 4 cancer, terminal, and cancer kills so many people unnecessarily, and so, really, we formed our statement around better utilisation of existing services and infrastructure that's already in place for Australians, that's proven our cancer screening treatment is the best in the world, and it is working, but, unfortunately, people with mental illness are not getting equal access to that.

So, really, most of our statement is about realigning the system so that people who live with mental health conditions get equal access to these services and equity of health outcomes, and I'm going to throw to John, because John's going to talk about some of those domains in mental health, in primary care, and also in chronic conditions where some of the things that we might be able to do. So I'll throw to John. You're on mute, John. Can I also say, before John comes in, the thing about these – this data which helped – ABS, we developed in partnership with the Australian Bureau of Statistics is every one of these people has had contact with a health professional about their mental illness, yet the screening and treatment rates are far lower. So this is not a hidden, hard-to-get community. These people are already having contact with health professionals, but, for some reason, they're not being segued into the treatments available. I will throw, again, to John. Thanks for delaying on mute.

DR ALLEN: Thank you, Russell. Look, very simply, I've been a clinician and I've been a director of services, I've done a lot of things. The tragedy for me is that when I see people with a mental illness, and some of the things that we help people with in their lives, the premature deaths is what's – and it's what's killing people, so the biggest cause of death with people with schizophrenia is not suicide it's actually smoking; okay, smoking-related diseases kills more people with schizophrenia than anything else, and so what we – what people have not done for a long time is take account of the physical affects – harmful physical illnesses that happens, but, as Russell says, there are many things that are just eminently preventable.

We all talk about things that are immediate, always to the short-term, and then on a policy position as well, but, immediately, things like vaccinations, screening for cancer, smoking-cessation programs, actually having people able to go to GPs will make a huge difference. We've already – and you've probably had evidence from this from – to work around the agreement, states and territories have actually taken this up. So a lot of really great programs that are already operating in states, like the

smoking cessation program that we worked on in Queensland, the vaccination programs for New South Wales, the online reporting in South Australia, the nurses that are embedded – Equally Well nurses embedded in Victoria, and so on, they're all happening in jurisdictions that could just be scaled up now, and it could be part of the national agreement, like, low-hanging fruit, straightaway you could do that.

It's also – some of the NGOs are doing great programs as well, like physical health prompts in their contracts, so they're actually not just doing psychosocial support, they're actually thinking about people's physical wellness, and one of the things that we need to change is the attitude that there's a difference between psychosocial support and health interventions – they're all the same thing – and we need to make sure that our NGOs and our services and the PHNs are all doing the same thing, not separating out those tasks, so that we're all talking about it and sharing to do that. We need to do that.

You know, you just had Brisbane North PHN on, and you said they're an exemplar. Well, they've actually got a physical health program; they got someone who's interested, and they lead that program, and Russell works with other PHNs that are now just starting to do those things, like shared-care models, and incentivising, and so on. So, you know, that's all their in process, but we haven't linked them up. The biggest barrier though to health is the primary care problem. I'm sure people come and talk to you about primary care concerns, about not having long enough to – and Dave mentioned – not having long enough to tell your story, not being able to get examined, not being able to afford the gap, not being able to afford the referral to specialists.

The GP system that isn't set up to do case conferencing, whereas, you know, you need to do that. You might need your support person to help you to do that, you might need to have a case conference with your case manager and so on. The public health system, we do them quite well, but we don't do them very well to link up all of those groups. You had the PHN and health service talking about that, but getting the private psychiatrist, getting the GP, being able to pay the NGO worker to case conference is a problem. So there are those things that need to happen, and about the sessions and so on as well, and I think that the other one that you asked about was alcohol and drug problem.

I just want to point out that in this world, the vast majority of people who have got a serious mental health problem, have got a serious drug and alcohol issue, or have had one, or have had to deal with one, and I've just been recently working with Mental Health Review Tribunal. About 80 per cent of the people that we see on orders have got a – have got or have had a comorbid drug problem, and services that don't look at that and don't treat that as part of the – contributing to the physical ill health and the mental ill health, are missing then boat. I will stop there.

MS LOUREY: So I'm just going to now jump up into the agreement and, essentially, you would have seen in our submission, we called for a national .....

DR JACKSON: I might just get you to stop there because - - -

MS LOUREY: - - - strategic - - -

DR JACKSON: Catherine, sorry, you're - - -

MS LOUREY: Yes.

DR JACKSON: - - - breaking up. It might be worth turning – and can we do this? Turn the camera off. Is that - - -

MS LOUREY: I can do that. Is that better?

DR JACKSON: Just so that we can hear you clearly, because your voice is just breaking up, and sometimes that can help with the bandwidth.

MS LOUREY: ..... we're moving now into ..... look like, and one of those ..... mental health . …. and that's because the issues that are around reducing that egregious harm that the system is really perpetuating on people with - - -

DR JACKSON: I'm really sorry, Catherine, but you are breaking up.

PROF ROBERTS: Cath, maybe we could try and paraphrase for you.

MS LOUREY: .....

DR JACKSON: I have to say, NBN has actually held up relatively well over the last day ..... I would say, overall. Well, I mean - - -

PROF ROBERTS: I was going to say, that might be another recommendation, is get increased bandwidth and fibre to the home. I think it's in the third talking point, and the recommendation is, because this is such a massive problem, for 22 per cent of the population, because it is also a preventable, there's – we can do interventions now that will make a difference in the next year, and the years after, we really think, this needs to – there needs to be an addendum with strategic plan and an implementation plan to address this issue. You know, the scope of this issue, while not diminishing suicide, is 20 to 30 times the scope, and while the suicide rate has been stubbornly resistant for the last 30-odd years, cancer rates, cardiovascular disease rates have plummeted.

So our services work. So we think this really warrants an addendum in terms of the national plan, and an implantation plan, with the resources and the details are there, like clear KPIs, clear actions, with the PHNs, with the jurisdictions and NGOs, and – but the resources to support the implementation and to monitor the implementation. If we do this, we will make a difference, we will save lives. I mean, you know, for example, cancer treatment's proven to save lives, vaccination's proven to save lives. All we need to do is articulate, and the mental health with the primary care, with the

chronic conditions sector together, to better utilise our investment and existing services, and some of that is also at the level of national preventive programs in the chronic conditions as well, because it's really a whole of service, whole of government response, and these are things that we can act on.

The social and commercial determinants are very hard to move, but the sorts of stuff we're focusing on are the things that we can move real quickly with – mostly with the resources and the infrastructure already in place. We just need to link people to them in a more equitable fashion, and that's really what our recommendations are with respect to the need for a national strategy, and implementation plan. We have a few other things in terms of the navigation, like supporting link workers, and the PHNs are, you know, great in that respect, the development of resources to better train and equip, people with living mental illness and the carers, and also to better train and educate people working in primary care, mental health care and the chronic conditions sector as well. We think that would have immediate benefit in terms of increasing equity of access to services. Cath, I hope I've done justice to what you were wanting to cover.

DR JACKSON: Sorry, Catherine. Did you have some questions? I was just going to ask around the National Stigma Strategy. So you would be aware that one of the – yes, in terms of the awareness campaign and I guess the barriers as you see them through access, and how much of that is around – I mean, stigma, when I'm really talking about, it sits within the medical profession itself, and we're just – I think they're about to release the inquiry here into women's access to health care in Victoria, and some of those issues, and just how they play out for people with mental health issues interacting with the broader health system, and what that – what that's leading to, and how a stigma strategy and its implantation might be able to address some of those issues.

PROF ROBERTS: Well, yes. The stigma strategy – and I would say go further – and also the discrimination reduction strategy, because a lot of the issues are around stigma, but also systemic discrimination where people with a mental illness are being discriminated against systemically. I mean, the other aspect, for one example, is diagnostic overshadowing. So people see someone with a mental health condition sees a clinician, and they see the mental illness. They don't see the person. And that's what we call diagnostic overshadowing. And so they focus on that mental illness and a person – and suicidality, which they should, but they forget about the major causes of death, you know? Respiratory disease, heart disease, cancer, diabetes etcetera.

So that's what we call diagnostic overshadowing, which is part of systemic discrimination, and it's also around people having unfortunate and bad experiences of contact with the health system. That's another form of discrimination. So they're less likely to access services when they really would need and would benefit from that. So we would be, you know, highly supportive of that, and it's also, in terms of the discrimination, it's increasing ..... health workers' awareness of the increased risk. The six times risk of breast cancer so that – and that's – it's more of an

affirmative action program, which is to deal with discrimination, to say people with mental illness require extra support because they have extra risk, they're carrying a much higher risk profile.

80 per cent of people with mental illness have a co-existing physical health mortality-related physical health condition, yet people treat them as if they don't. So once again, that's a – sort of the reverse discrimination. So we would be highly supportive of the release of that stigma reduction and discrimination reduction strategy.

DR ALLAN: Can I just add another comment to it? When you look at national prevention strategies like heart disease, or cancer, or respiratory disease, the main – the people who are actually dying in that group, the overrepresentation, are actually the people with mental illness, but they're not actually taking that into account in that work. So it's not just the – for the mental health world to take notice. It's actually for the general health world to take notice of the fact that the people that they should be helping – and it would make their statistics look much better if they actually did help them, are the ones that they're ignoring.

And so they're not deliberately discriminating. They're just not seeing the issue from the point of view of the person. A good example is when we did the smoking elimination in Queensland, we got the Quitline to rewrite their support program, taking into account that a person who has got a severe mental illness, will need extra sessions, will need more time to explain and will need a bit of – you know, couple of extra phone calls. You can't just do it all in once, and once you do that, you get great success. It's simple.

PROF ROBERTS: And likewise, in New Zealand, the health department in New Zealand for cardiologist have 29 years of age for risk of heart disease for people with serious mental illness. So they've – in their policies, they're recognising the increased risk, and really think in terms of the clinical guidelines, that should be the case too, and the data is there to inform that. I just think there's a bit of inertia in terms of updating those things. That's why, you know, we say there's the urgency to sort of act on this.

DR JACKSON: Thank you.

MR BUTTON: And I just want to pick up on a couple of specific things. You mentioned some of the work that's going on with Equally Well nurses working with GPs and working with multidisciplinary teams. I know when we caught up – can't remember when that was? Was last week or the week before, when we had the online chat.

PROF ROBERTS: Yes.

MR BUTTON: We dialled in a nurse who was working in a multidisciplinary team at a hospital at that time. I can't remember her name, but she talked about the work

that she was doing. Have you got any case studies or evaluations, that you've written up some of these that you could provide to us that demonstrate how these are working, and the impact it's actually having in multidisciplinary team models as well to support people experiencing mental health, as well ensuring that they actually need the support for a range of other conditions.

PROF ROBERTS: Yes, that was Trudy Brown, who's a nurse practitioner in Victoria – in multi-D team in Victoria, and there's a number of people like Trudy. So, yes, it was remarkable, her story, in terms of, you know, simply asking people if they had their screening, and five out of six hadn't. No, it's of the six that hadn't, five out of six said, yes, can I please have it? So those people had never been asked. So I think that's a – we would love to write up that case study. In fact, we've asked Trudy if she could give some examples, and there's other case studies of mental health teams who have sort of gone into GP practices, no funding at all, no implication for the GP practice.

It has been through three GP practice managers, and the mental health team just reach out, and once a week they have a clinic, and they have the data on the dramatic reduction in ED department admissions, a dramatic reduction in unplanned hospital admissions, that that's done by just having better protective preventive care for people in the community, and also so the GP and member of mental health team, they see the consumer together, you know, one morning a week, and that's a clinic up in Mudgee. So we can certainly send the published -the peer review papers on that project. It has been going for 15 years now, so it is sustainable. With no additional funding. It's just about joining those two – local initiative, joining two services together.

MR BUTTON: And certainly it was going – building on that, there was a question that I had then in respect of, potentially, if some of the incentives that might be required, particularly if you're focusing on GPs and where we're wanting GPs to think more about broader experiences outside of – just focusing on the mental health component. Is it – and I'm not leading you to answer this, but is it worth thinking about additional incentives as in additional MBS items that might be then more incentive in the GPs, to then start to focus on those additional pieces as well.

PROF ROBERTS: I think we're on the same page, Sel. I think we've actually mentioned this as one of our recommendations, and I've just come straight out of a community of practice with – that we have with the PHNs around Equally Well, and Central Eastern Sydney PHN is doing this, and they're incentivising GP practices. So we do have that pilot study. So they're really doing some wonderful work with shared care and incentivising GP practices. If we could scale that up. That's another example of successful programs that could be scaled up. So, yes, I completely agree. I think that's a real missing part, and we do need to understand the financial imperatives of GP practices, and work within those.

DR JACKSON: yes, that – so that was Eastern Sydney?

PROF ROBERTS: Central Eastern Sydney – CESPHN, we call it. C-E-S-P-H-N.

MR BUTTON: Certainly coming back to John's earlier comment about case conferencing, and how case conferencing is done differently in a public hospital setting, as opposed to what happens in a GP setting, and if there's that notion, and we've heard this certainly from carer groups as well, that if – how do we ensure that we're incentivising carer involvement in case conferencing with the person that they're supporting, who's having mental health experiences, and is there a process to look at incentivising that for the GP to include them in that conversation as well.

MR ALLAN: We only pay GPs when they're – someone's in front of them most of the time, unless the PHN pays them to do a particular task. We should be paying them for their expertise to contribute to other care. GPs are specialists in primary care. We should be paying for that specialist input into the system. David probably will talk a bit further about that, but you know, we have to link it all together.

PROF ROBERTS: And Sel, before we throw to Dave, I think on that, there's two ways we could approach that. One is, like, incentivise GPs to do multidisciplinary case conferencing virtually, so they can have that as an MBS item, and I think you remember Simone McCallum, Dr Simone McCallum, a GP that's going into a multidisciplinary team, and she's loving it. She's working with a team. GPs are often isolated, so I think also putting some support to public mental health services to support that more, to fund GPs to come in as sessional into multidisciplinary teams. So I think there's two ways of getting GPs involved in multidisciplinary care, and I think that would be tremendous benefit to people living with mental health. That - - -

DR JACKSON: Might go to you, and then we are going to have to wrap up, unfortunately. We're a bit time-limited today.

PROF ROBERTS: Yes. Sure.

DR JACKSON: But we ..... Thank you again to Equally Well for all your involvement in the inquiry so far. It has been, yes, very – we are very grateful to you for sharing your expertise and knowledge with us. So, Dave, sorry.

MR PETERS: Thank you, no, no. It's all right. It's – just the – it's hard to vocalise the impact of unsuccessful care, as opposed to successful care. Like, just a small change can make a massive difference to someone's life, and give you hope for the future that you're suddenly willing to put effort and time into making changes that you can control. You know, unfortunate nature of sort of a change of policy in government systems in the introduction of NDIS sort of taking over from Partners in Recovery, and seeing that sort of case coordination – specialist case coordination role sort of departing in favour of the NDIS, and then the NDIS being very, very firm in their boundary of not doing – not replicating any health-related services.

So it was a – yes, the idea was there, that the NDIS could provide an equivalent service of case coordination, and sort of the care coordination, but the practice was that it's very firmly no. So it's a real loss, because that was a very successful program with some great outcomes, you know, leading to previously unmet needs of decades. So it's just an unfortunate – yes. Unfortunate situation but, yes, the impact of successful care can be multilayered and, you know, such as detecting cancer at stage 1. You know, all kinds of interventions can have that – early intervention can have that kind of positive impact where change is suddenly possible.

DR JACKSON: ..... Thank you.

MS LOUREY: And of course peer work.

DR JACKSON: Yes.

PROF ROBERTS: Exactly.

MR PETERS: And peer work.

MS LOUREY: .....

MR PETERS: Absolutely.

MS LOUREY: Multidisciplinary team.

PROF ROBERTS: Angela and Sel, thank you for your time. It's a big day for you, and we really appreciate - - -

MR PETERS: Yes.

PROF ROBERTS: - - - the opportunity.

DR ALLAN: Yes.

MR ROBERTS: Thank you for that.

DR JACKSON: Not at all. No, thank you.

MR BUTTON: Thank you. Appreciate your time.

MR ALLAN: Thank you.

PROF ROBERTS: Thanks very much. Bye.

MS LOUREY: Thanks. Bye.

DR JACKSON: Sorry, Catherine, for ..... We now, I believe, have Mental Health Australia, and Emma. Good afternoon.

MS C. NIKOLOSKI: Hi. Yes, you can see me?

DR JACKSON: Hi, how are you?

MS NIKOLOSKI: Yes, well, thank you. How are you?

DR JACKSON: ..... thank you. Hi, Emma, how are you?

MS E. GREENEY: Hello. Hello, Commissioners.

DR JACKSON: Good afternoon. I might just start by asking you both to introduce yourself formally for the transcript, and invite you to provide any opening statement before we move into a little less formal Q and A, but it's lovely to see both of you.

MS NIKOLOSKI: Yes, sounds great. So I'm Carolyn Nikoloski. I'm the CEO of Mental Health Australia. Emma.

MS GREENEY: And I'm Emma Greeney, the director of policy and advocacy at Mental Health Australia.

MS NIKOLOSKI: So I can provide just a few opening remarks before we get to questions. So thank you so much for the opportunity to speak with you today, and contribute to this significant review of the national agreement. As you're aware, Mental Health Australia is the national independent peak body for the mental health sector. We have 150 member organisations, including service providers, mental health professional associations, lived experience representative groups, carer advocates, along with researchers and other stakeholders, and I would like to just thank and acknowledge the members who have informed our submission, and our response today.

So, firstly, it's really clear that the Productivity Commission's interim report, it shows that you have deeply listened and engaged with the mental health sector and the community to inform this review so far. So I wanted to acknowledge that up-front, and thank you for that deep engagement that you have had with the sector and community, and, overall, Mental Health Australia really strongly supports the majority of the Commission's draft findings and recommendations, and, as you've found, while aspects of the National Mental Health and Suicide Prevention Agreement are commendable, unfortunately, it has been limited in its effectiveness and wasn't set up for success from the start. So we strongly agree that we need a new and more effective agreement, one that sets out really clear and connected objectives, includes measurable outcomes and funded commitments to deliver on real reform. There also needs to be a far greater accountability for governments to deliver on the agreement, with really robust mechanisms to do so, particularly in partnership with the experience representatives and the sector.

So Mental Health Australia, in particular, welcomes the Commission's recommendation to develop a renewed mental health strategy. As we've advocated for quite some time, such a strategy is really essential to providing a unified direction for long-term and interjurisdictional reform, and it's really critical that that strategy is developed through a co-design approach with people with lived experience, mental health carers and the mental health sector, along with state and territory governments. That process is really important for the legitimacy and effectiveness of the strategy, and, ideally, it would be something that has bipartisan support so that it can guide investments over multiple election terms. That, of course, is a significant piece of work and will take time.

So we understand the rationale for proposing an extension to the current agreement while that strategy is developed; however, we are concerned that such a delay would unnecessarily stall action on immediate priorities and still also not provide enough time to both develop that updated strategy along with the next agreement, and it would also extend existing ineffective governance arrangements. So we think there's really urgent work that governments in the sector already agree is needed, so areas such as addressing the gap in psychosocial supports along with improving children's access to mental health services and progressing workforce reform, and we don't think we can wait another year or more for governments to act in these areas.

So an alternative approach that we're recommending is that governments engage with people with lived experience, family, carers and kin, and the sector to develop up overarching objectives to guide the next agreement and progress these priority reforms without delay through a new agreement that would commence on 1 July 2026, and then the national mental health strategy could be delivered as a commitment within that next agreement to give appropriate time for co-design. So we think that approach would better balance the need for immediate action along with long-term reform.

And I also just wanted to comment on the opportunity to improve some of the governance mechanisms that government could and should make immediately. So we'd really like to see even stronger recommendations in the Commission's final report to strengthen sector lived experience and carer involvement across all governance levels and forums under the agreement. We think these are really important transparency and accountability measures, and we are also strongly backing the Commission's recommendations to improve monitoring and reporting through a strengthened role of the National Mental Health Commission.

We also welcome the Productivity Commission's consideration of ways to improve a whole-of-Government approach to mental health through the next agreement; however, we are concerned that the current proposal for the Department of Prime Minister and Cabinet to lead negotiation of the agreement may risk losing important mental health expertise and stakeholder relationships, so we propose that funded mechanisms would be a more effective mechanism to drive that cross-portfolio action on social determinants of health.

And, finally, I just wanted to touch on that we really welcome the Commission's consideration of improved funding mechanisms for mental health services, and we recommend that the next agreement should include commitments to improve sustainability, commissioning and contracting of mental health services, and we've developed a perceptive sustainability statement that outlines how those services could be improved and the funding arrangements behind them, and we also particularly look forward to the Commission's findings on the potential for the interaction with the National Health Reform Agreement to really free up activity-based funding to support community based care. So I note that was quite a long opening statement, so I will leave it there, and pass it back to you for questions.

DR JACKSON: Do you want to take this? Yes. Go on.

MR BUTTON: I'm going to come back – thanks, Carolyn; really appreciate that, and good to see you both again. If I start, I guess, with strategy and the new – the next agreement, and, certainly, I guess, as you – as it's articulated in the interim report, the whole notion of the delays to make sure that there's a direct connection to a broader strategy for a new agreement, but you're suggesting that a new agreement can have and has a deliverable of the new agreement will be the development of a new strategy. I guess – and I certainly appreciate that. There's a bit of the chicken or the egg there, so can you talk us through some of that, because I guess we're – what we've heard is, and where that's coming from is we want to make sure that there is an absolute connection going forward that the long-term vision sets out what the short-term arrangement of an agreement might be able to achieve across a five-year period.

MS NIKOLOSKI: Yes, absolutely. And, certainly, we recognise the importance and the significant gap that we've got at the moment in not having a strategy. So we're absolutely supportive of the need to have a national strategy to guide our collective investments over, I think it was a 30-year period that the Commission recommended. So we're really supportive of that approach. I think our concern was that it may stall action in the meantime, and it kind of gives government a reason to not progress some priority reforms that we know desperately need to be done in the meantime, and I think there is strong alignment in this sector on priorities that could be actioned in the short-term through the next national agreement while we really take the time to develop up that national strategy through a co-design approach that includes the buy-in from lived experience and carer representatives along with the broader sector and across all levels of government. I think that will take time to get it right, but, hopefully, by investing in those relationships in the process of development, we'd get better outcomes in the long-term while not stalling action in the meantime. Emma, did you want to build on that?

MS E. GREENEY: Yes. Thank you, Carolyn. I completely agree. There are one or two other thoughts that come to mind in relation to this issue: one is actually conversations with we've had with Suicide Prevention Australia, and we work quite closely with them and have done over the last couple of years as they've worked to get release of the National Suicide Prevention Strategy, and that was a really large-scale body of work that has set a very ambitious agenda, but it took quite a bit of

time to get there, not just to do the actual consultation, but also, then, the socialisation within government.

There were aspects of that strategy that reached into other portfolios which, naturally, did take time to make its way through Cabinet processes, etcetera, and so in speaking with our colleagues in SPA, they certainly recommended that several years is needed to really drive the kind of breadth and depth that you would need in that sort of a strategy to be successful, and I think, secondarily, I draw from the experience – so, in Victoria, an equivalent example I often think of is the work of Infrastructure Victoria, which sets out these really long-term bodies of work often looking 30 years down the track, and, of course, they're looking at big, broad brushstroke issues like population growth and what the needs of the metropolitan and regional communities will be, but one of the processes that Infrastructure Victoria uses in setting its 20 to 30 year report deadlines is that they engage across the political divide, because they recognise that, for the work they do to have longevity beyond electoral cycles they need to have buy-in from both major parties, from both the current government and the current opposition, and I actually think that that's an avenue that would be of great value in the mental health sector in setting our broad national strategy, because we do want this to live beyond just a current electoral cycle, and I would argue some of the problems we saw in the current agreement in its establishment were driven by the timeframes of electoral politics and by the need to plan things within a certain timeframe that are aligned with a particular current government's narrative, but having that extra occasion and the platform of a national agreement signed up to by the Commonwealth and all states and territories could be an incredibly valuable platform to set a bipartisan, truly community-led agenda for mental health over the coming decades, and an outcome like that will need more than the 12 to 24 months that would currently be envisaged, we feel.

MR BUTTON: Okay. So - - -

DR JACKSON: Yes. I mean, one of, I guess – and this isn't – we're not going to get into an argument here, but is that there is actually a lot of the planks, if you like, of a national strategy are already in existence, so the amount of – I mean, and part of our thinking in terms of that timeframe really wasn't that we would go back and necessarily reinvent the wheel from 2008, but more through a co-design process, look at, well, what's currently in place, what additional things do we need to bring it all together rather than, you know, redoing the whole – I guess the whole policy area, but are you envisaging something that does do a complete refresh or – because I think .....

MS NIKOLOSKI: I think, in essence - - -

DR JACKSON: - - - we were thinking it was bringing together what's already out there of which there are many different parts already - - -

MS NIKOLOSKI: Yes.

DR JACKSON: - - - .....

MS NIKOLOSKI: Yes. I mean, there are different options. Obviously, we could just refresh what's already there or go through that very comprehensive development process. I think our major concern, though, is what's the unintended consequences of delaying action while that strategy is developed, and that's where I think there's already kind of agreement on what needs to be progressed and hasn't been progressed through the current agreement. So our concerns would be allayed if we had that reassurance that governments are committing to action and investments in the next year while that strategy is being developed; that's a real concern about the delay in action and investments rather than the strategy in and of itself - - -

DR JACKSON: Yes, I know. I understand.

MS NIKOLOSKI: - - - which we're absolutely supportive of. It's just the unintended consequence of it.

DR JACKSON: I will just follow on. I think the other area you raised was around where the negotiations occur - - -

MS NIKOLOSKI: Yes, yes.

DR JACKSON: - - - and whether these – again, we're getting quite technical, but we're in a review of a national agreement, so I guess we're in technical land. One of the concerns that we've got that, I guess, the current agreement and not fulfilling its objectives, which were commendable, was that whole-of-government approach, and saying that mental health is not just siloed within the health sphere, but that it's actually a much broader issue, and needs a whole-of-government approach, but it hasn't quite delivered on that either, in terms of governance or actually actions, and that, from our mind, that centring it around the Department of Prime Minister and Cabinet and when we're thinking through that, we're also thinking the premier's departments at the state level, gives, I guess, the agreement, the focus, that it needs a whole-of-government focus for accountability and governance that can really drive a whole-of-government approach to the systems change we need to address mental health issues in the community, but your view is, obviously – and I think what you were saying was that it should remain within health and health's purview?

MS NIKOLOSKI: That's right. So we definitely support the idea of having that whole-of-government approach to mental health reform, and that's been well-documented and needed for a long time now. I think there are lots of ways – different ways – to achieve that outcome, and, certainly, when we chatted with our colleagues in the Department of Prime Minister and Cabinet, they really highlighted that the missing gap in this agreement has been the lack of funded programs that enable and require whole-of-government action in mental health, and it's been the lack of funding to drive the whole-of-government action that has been the biggest barrier rather than who's responsible for leading the negotiations of the agreement.

So when we're – we're thinking about, like, pragmatically, where does the skills and expertise and relationships lie, we landed on a view that they're currently within the Department of Health. We can absolutely achieve that goal and outcome of taking a whole-of-a-government approach that do so more from a – let's be clear about what's going to be funded that will drive whole-of-government action, and also what are the accountability mechanisms that we can put in place to ensure that those actions are actually delivered, because I think it's been clear through this current agreement that that has fallen down, and despite the best attempts, it hasn't worked, so we need to look at how we can refresh that approach. Emma, did you want to add anything to that?

MS GREENEY: Just also that the experience and expertise in engaging with lived experience communities is really vital to this work, and, you know, it's – we've still got a long way to go in best practice with that, but the green shoot6 that we do have, exist for the most part, in health departments around the country not in central agencies, and, though, you know, we have a very good relationship with our Commonwealth department and, indeed, with Minister Butler, who seems very passionate about this space, there's varying levels of commitment and interest in mental health reform within the state and territory governments, to our observation, and I think for that framework to succeed you would need all the DPCs and DPMCs together, which seems like a tall order, when it's not the typical approach for a national agreement negotiations, and so I think between needing to make sure we have connection to sector lived experience expertise and also, you know, equal negotiating platforms between jurisdictions, it seems, in that – on that balance, we would preference the Department of Health.

MR BUTTON: Okay. That's right. I want to go to the governance, because you mentioned governance, and I guess what I'm hearing is that you don't necessarily think the current governance arrangements are the best reflection of all groups. Talk to us a little bit more about that.

MS NIKOLOSKI: Yes. So I think, as you found in the interim report, I don't think the governance arrangements currently are effective and there is a lack of transparency about which governance forums and discussing and deciding on what and who is involved in those discussions, and it's also a mixed bag in terms of what level of sector and lived experience representation is included in the governance forums, and, certainly, I know that you're chatting with the Mental Health and Suicide Prevention senior officials lived experience group, I think it's next week, to hear their direct insights on their engagement with the governance forums, and, certainly Mental Health Australia has facilitated the establishment of that group which was late in the piece in the implementation of the agreement, so that work was kind of behind before they even began, but so there is definitely significant opportunities to ensure that lived experience and carer representatives are embedded across all governance groups associated with the agreement, but there's also a need to ensure that broader sector representation is involved in the agreement, and, certainly, we, as the peak body, are included in a couple of the working groups that report up to MHSPSO, but there's no consistency in terms of which groups the sector is or isn't

involved in, and I think, when we think about the implementation of the agreement, we really need to be bringing together that expertise from government along with the sector and those that are responsible for delivering a lot of these services on the ground along, of course, with the lived experience expertise, and it's only by combining all of those views that we will get a stronger reflection on what's really happening and where are the opportunities for improvement.

And I think just back to my earlier comments about the lack of transparency on what's actually happening, like, that makes it very difficult for us as a peak body and others in the sector to actually know how effective the agreement is being. So there needs to be that immediate improvement in the sharing of information about the governance arrangements, so that we can all have a shared understanding in terms of the current state and how we can fulfil our role to ensure that the agreement's being implemented as effectively as possible, and we can provide our insights on what the experience is on the ground.

MR BUTTON: Is that also a reflection of what governance arrangements look like at the jurisdictional level as well, Carolyn?

MS NIKOLOSKI: Yes, that's right. And I think certainly our reflection is that it's a mixed bag in terms of the engagement of state and territory governments, in particular, in participating in those governance forums, so that makes it really difficult to drive action when there's a lack of commitment across the jurisdictions, so that's from our experience on sitting on a couple of the groups, but, again, because we don't have that – there's not that transparency of information it is somewhat difficult to make an informed comment. Emma, is there anything else you wanted to add on governance?

MS GREENEY: Just really an addendum to your very final point, Carolyn, which is that issue of transparency and data, which is that not only is it vital for there to be sector expertise as implementation occurs, but where there are instances, as we've seen, and, actually, the Productivity Commission's interim report helped us understand in greater detail where there are instances that jurisdictions have fallen behind in their commitments or failed to deliver to the extent that was originally envisaged.

The sector would have loved to come together and either offer collaboration to address that, or, at the very least, make accountable the governments that are not delivering what they've promised their communities, and it's been very hard for us to find enough information and data to make that possible, and I think, then, that really – you know, that impacts credibility and trust in the role of a national agreement and in the commitments of governments to improve the mental health of their communities.

DR JACKSON: Yes. I'd also add it's difficult, like, even for organisations, a lot of this research is as you're aware, in this space is actually the quality of information and the public release, the biggest impact is on the organisation itself for the body can

then respond, but without that transparency you might not even know that you're actually falling below - - -

MS GREENEY: Yes.

DR JACKSON: - - - the par, but then – but – yes.

MS NIKOLOSKI: Yes. Absolutely.

MR BUTTON: And just on the accountability and reporting comment, Emma, and not, again, leading you to anything, that's – for saying something that we think you were going to say, but, then, obviously, the commentary and the interim report recommendations about public accountability and reporting and adding in, essentially, what might be a data dashboard going forward that's publicly available for people to have a look at performance, I guess your thoughts and what that might look like?

MS NIKOLOSKI: Yes. Emma, did you want to .....

MS GREENEY: I certainly - - -

MS NIKOLOSKI: Yes.

MS GREENEY: I certainly support it for multiple reasons. I've previously had experience in the Victorian system and through the Royal Commission, and the constant refrain from the very day that report came out was, "Can we track what is happening", "Where can we see what is being achieved and what is still to come, and how far we are," and that opacity that is being experienced in the Victorian Royal Commission has been a huge problem. So building our – a platform that addresses that from the outset is vital.

The other thing I would say, again, from a Victorian perspective is a commitment was made in the 2014 state election to provide an annual mental health report that had to be tabled publicly in Parliament, and that one commitment probably had some of the most significant improvements in more timely reactions and responses to failures in the system, because the Minister and the department knew that, at the same point in time every year, that report was going to be published, and the sector knew it was coming, advocates knew it was coming, it had to be released, and it meant that you – there was a pressure incumbent on ministers and senior officials to make sure they were tracking against what – their performance, because the annual report was laid all there, and that – that engendered an environment of accountability and transparency that, I think, if we hadn't had that, we would be far worse off.

So, certainly, anything that the Productivity Commission can recommend, definitely, it needs to have a requirement for public release within a timeframe, that's how it was done legislatively in Victoria within a certain number of sitting days, and with access to, you know, regular data; there was to be a dashboard. I think that's where

you'd need input and leadership from the sector and, like, organisations who provide services, to make sure that it's not a significant burden on them administratively for the benefit that we get, which is that transparency of data. I won't speak to how the departments would feel about that. I'm sure it's a lot of additional admin for them, but so it goes when using public funds.

MR BUTTON: Yes. The other thing you mentioned the last time we met – and I'm testing this, because it may have shifted here a little bit – but when we first had the conversation about accountability processes, at that point we were talking about a connection to National Cabinet to give it that national prominence, but now you're suggesting – and, I guess, our response, as part of the process, is to look at, then, Prime Minister and Cabinet leading the coordination of some of those arrangements in terms of negotiation of a new agreement.

Now you guys are saying, "We don't think that that's necessary. We want to make sure that there's – we're having the policy experts from Health involved in leading negotiations," but, I guess, what I'm trying to get at is how do we make sure, then, the cross-portfolio issue and the cross-portfolio initiatives that do come up in the agreement which are – which are significant, and there's been a lack of progress on how do we ensure that we're getting that continuing, not just at a national level, but then also the jurisdictional level, so that – I mean, Victoria's case, you might – it might be okay, because you've got the annual mental health report that's tabled in Parliament that talks about performance across agencies, but without those sort of things in place, how do we make sure that we've got cross-portfolio, I guess, spotlight on things that are required through the agreement?

MS NIKOLOSKI: Emma, did you want to answer that one initially, or would you like me to?

MS GREENEY: All I'll say is it's a tough one, because I know we'll be competing with lots of other social policy areas that wind up having a cross-portfolio flavour. Again, drawing on the Victorian experience in the wake of the Royal Commission, a separate Cabinet committee was established to guide the implementation of Royal Commission recommendations that sat outside the mental health portfolio, and that was effective, but I don't know the likelihood of seeing that structure replicated in every jurisdiction when we do have such different appetites and attitudes to it. I do just agree that, without there being some mechanism to hold ministers, who have other portfolio responsibilities, to those commitments it is tricky, but I'm afraid I can't offer further advice or insights on it .....

DR JACKSON: That's okay. Take it on notice.

MS NIKOLOSKI: Yes. I think the only other thing I'd add to that is that is that, like, funding and then what are the reporting mechanisms that are put in place to ensure that that funding is used as intended, and what outcomes are being achieved through it. So I think they're two potential opportunities to look at how can we ensure that they get the best outcomes that they need, and that there is accountability

for delivering on what has been funded, and that's where I think the current agreement has let us down, because there's been intent to progress things across other portfolio areas, but they haven't come with any funding, and, therefore, it hasn't been done, because it hasn't been on a priority list. So ensuring that there are funded commitments, that's one way to driving that cross-portfolio action, but it's a tricky one.

MR BUTTON: Okay.

DR JACKSON: I think - - -

MS GREENEY: If I could just add one last thing which is that the very process that governments go through in approving the negotiating parameters for a national agreement is a very good opportunity to leverage commitments in other portfolios, because it has to be approved at Cabinet. So if it were the case that, say, housing instability was selected as an area for reform – as an example – and you needed to get parameters approved, the housing ministers – at Cabinet, they could co-sign the Cabinet submission that goes through the various governments to get that approval for the expenditure in principle – obviously, it's all still subject to the Treasurer signing it off, but I think that wasn't followed at the last agreement, it was just all taken by Mental Health Ministers, no money was put into other portfolio responsibilities, and then it was just a question of if, out of the goodness of their hearts, ministers in other portfolio areas cared to put up proposals through regular budget phases that enabled that, and with so many competing priorities it's not surprising that that did not happen.

DR JACKSON: Yes. And I think that's probably, to be fair – and, like, well, is our concern is that that, realistically, from your experience, without central agencies driving this really, without the Prime Minister's Department or Premier's Department you just don't get that ownership you know, like that's a coordinating – that's the coordinating mechanism, and that's not to downplay the expertise that line agencies obviously bring to certain policy areas, but that coordinating function, it would be difficulty for a line agency to do with other departments; that's really the core function of a central agency, but, look, thank you. I mean, we take on board the feedback and the reflections, and the - - -

MR BUTTON: And we – we've now removed the question on notice that we were about to submit you for that answer, as well, Emma.

MR BUTTON: Thank you for appearing today, and for your comments.

MS NIKOLOSKI: Yes. Thank you so much for the opportunity. Thank you.

MS GREENEY: Thank you.

MS NIKOLOSKI: Bye bye.

MR BUTTON: And now – now we have a short break, and we will come back at

DR JACKSON: 4 o'clock.

MR BUTTON: 4 o'clock.

DR JACKSON: Yes. See you then. Thank you.

ADJOURNED **[3.34 pm]**

RESUMED **[4.00 pm]**

MR BUTTON: Thanks, everyone. We'll now resume our public hearings for the Productivity Commission review of the National Mental Health and Suicide Prevention Agreement, and for our last session this afternoon, we've got the team from Mental Health Lived Experience Peak of Queensland. I know we've got a few people that will be joining us online. I'll give it a – just a little bit for the tech to work and for the guys to come on, and then we can kick off.

MR BUTTON: Thanks, everyone, for joining us this afternoon. What we will get you guys to do is, when you – before you kick off and go into your opening statements, is if you can introduce yourselves, your name, title, etcetera, so that at least we've got that recorded for the transcript as well.

MR S. KATTERL: Thank you. Thank you. Well, we'll start off, then, and a pleasure to be with you today. So my name's Simon Katterl, he/him pronouns, working with the Mental Health Lived Experience Peak Queensland. I believe you – you might have slides with you. We thought not to share screens because it'd distract too much from this, but if you've got them, we provided them - - -

DR JACKSON: Yes.

MR KATTERL: - - - only a little bit earlier today.

MR BUTTON: We've got them, so, thank you.

DR JACKSON: Thank you.

MR KATTERL: Wonderful. We'll begin by acknowledging country. I'd like to acknowledge the traditional owners of the lands that we're joining in from today. I'm joining in from – and I know others will be joining in from other country – the Yuggera and Turrbal People and pay our respects to elders, past and present and any First Nations members and leaders here today, and affirm that sovereignty was never ceded. So we are from the Mental Health Lived Experience Peak Queensland. I won't talk too much about our organisational context; that's kind of unpacked in our submission, but today we have three wonderful speakers, and I'm just really providing a scaffold to this.

So I'm the CEO of Mental Health Lived Experience Peak Queensland. We also have Paula Arro, who's a member and Lived Experience Leader who will be speaking; we have Danie Williams-Brennan, who's our policy director; and Nyoka Fetoa'i, our co-chair of the organisation. So what I will do is I'll hand over now to Paula Arro, who's going to provide a bit of an introduction to the importance of acknowledging and clarifying the purpose of the system through the agreement.

MS P. ARRO: Thanks, Simon, and thank you for meeting with us again today. So, look, I just want to kick-off with, you know, old Einstein's definition of insanity is doing the same thing over and over and expecting a different result, and I picked up a bit of that in the Commission's interim report. Just there's three key points I'd like to just briefly raise right now is that, you know, the system is causing harm. We

know it through – that people are not getting well. We've got data, and the Commissioners reflected this throughout. We're still operating on a medical deficit-based model, where we really do need to stop the – it's the motherhood statement, actually – really build a culture of person-centred, trauma-informed, culturally safe system.

The second point I'd like to make is the big C-words that's mentioned throughout the document and, by that, I mean "co-design" and "co-production". We're still seeing very tokenistic gestures of what co-design and co-production mean to the system as opposed to what it means to people like myself who have a lived experience. I think – I'm happy to provide a range of good and bad examples in discussion time if you see fit. The third point, and probably a solution-focussed point is around, you know, how do we build this commitment and culture of transformative change, and this is only going to happen through good governance, accountability and transparency.

There's a trillion lived-experience-led resources, research, guidelines, frameworks, etcetera, that have been developed, particularly over the last five to 10 years, so the answers are there. I – and we just need, now, to implement. No more – we don't need to develop any more guidelines and frameworks; the answers are there, and we just need to get into action. I'd particularly light to highlight, in terms of the harm, the "shining the light" position paper that MHLEPQ wrote, and there's a number of other ones – because I'm nervous my brain has just gone blank.

And then in terms of the co-design and lived experience governance, there's a resource that was genuinely co-produced called the Lived Experience Governance Framework: Centring People, Identity and HR, and that has five domains that need to be incorporated in any future governance right from that very word "go" at the agreement phase, filtering down. There's five domains – very quickly: a partnership and co-production; safeguarding responsibility and power; lived experience involvement, expertise and leadership; transformative workfaces and practices; innovation and continuous improvement. So I just encourage the Commission to take note and take a look at some very clear recommendations that have been made over and over in many reports. Thank you.

DR JACKSON: Thank you.

MR BUTTON: Thanks, Paula.

MR KATTERL: I'll pass to Danie, our policy director.

MS ARRO: Handball to Danie.

MS D. WILLIAMS-BRENNAN: Hello, everyone. I'm Danie, I'm the policy director. Today I'm going to have a quick discussion about the arguments why a human rights framework should be put into the recommendations and into the agreements. I'll start by saying three things: the current interim agreement does not discuss the coercive elements of the mental health system; the second point is that

human rights are mentioned only once, and that's in the body of the interim report; and completely absent – being the third thing – is any acknowledgement of the impact the social determinants of life has on a person.

So keeping this in mind, and also keeping in mind our obligations under, firstly, the Convention on the Rights of Persons with Disabilities; and, second, the moral significance of the United Nations Declarations on the Rights of Indigenous Peoples, we strongly argue that human rights must be a framework applied across the recommendations made and the ultimate agreement. Now, in order for this to be successful, we do state that it ..... needs the aid of a national human rights Act, and we do, in conclusion, state that if there's no human rights framework, then we're just going to have this continue reliance on a coercive, clinical system that doesn't value the person, who they are, or what their needs may be. Thank you.

DR JACKSON: Thank you.

MR BUTTON: Thanks, Danie.

MR KATTERL: Okay. To the wonderful Nyoka.

MS N. FETOA'I: Thank you very much. Look, mine's probably a little bit more personal and, Paula, I get really nervous as well, so I've written everything down. Apologies in advance if I read.

MS ARRO: You've got this. You've got this.

MS FETOA'I: So I'd like to begin by acknowledging the traditional owners of the land each of us are gathering on. I come to you today from Darumbal Country. I'm a Darumbal woman from Central Queensland. In 2009, my mother gave evidence to a Senate Inquiry after losing my younger brother, Ang, to suicide. She wanted change so that other families would not suffer as we had, but, three years later, she also took her life, and, then, eight years after that, my older brother, AJ, passed away. I'm the only one left of my immediate family, and I stand here before you today as a First Nations woman, a mother, and as the acting co-chair of Mental Health Lived Experience Peak Queensland. I'm here because our children, no matter their age, must not see suicide as an option when life gets hard; that's what I truly believe.

Suicide is still the leading cause of death for our young people. Many grow up facing racism, poverty and disconnection from culture, who often services only reach them at crisis point, in emergency departments and in police cells. If the next agreement is to save lives, it must place prevention for our youth front and centre, that means investing in culture, in community connection and in peer support designed by young people themselves.

Aboriginal community-controlled health organisations are trusted anchors in our communities, but they cannot carry this responsibility alone. There are also many other Aboriginal community-controlled organisations, such as those in housing,

justice, child safety and family services and cultural healing that must be resourced appropriately. This ensures that First Nations people have real choice in whether – where and how they seek support. At the same time, our people must walk into mainstream systems every day, including emergency departments, child protection and the police and feel safe and know that – sorry – the spaces where our people are most at risk will remain safe and accountable.

The dedicated social and emotional wellbeing schedule is critical, but it must not be limited. If it focuses only on ACCHOs, the mainstream systems will continue to retraumatise our people. If it focusses only on mainstream services, we lose the strength of our community control. The schedule must embed both ACCHOs, other community-controlled organisations and mainstream services working together, co-designed with First Nations lived experience leadership.

Every suicide is a lesson. Coronial processes too often miss the truth of our losses. Reports may point to alcohol or mental illness while ignoring racism, poverty and cultural disconnection. With targeted funding, the Coroner's Court could build cultural capability to learn from suicide in our community so families see dignity in the process and so governments are held accountable to the real drivers of distress.

In closing, I want to leave you with three clear messages: the needs of our First Nations youth must be front and centre; authentic co-design must extend beyond ACCHOs into other Aboriginal community controlled organisations and all mainstream services; the social and emotional wellbeing schedule must fund ACCHOs, other community controlled organisations and mainstream services with capability uplift, starting with the Coroner's Court. We cannot afford another generation of unmet commitments. My mother's words were recorded in 2009. 16 years later, I'm still asking for the same thing. Our families, especially our young people, deserve more than words on paper; they deserve action that saves lives.

MR BUTTON: Thanks very much. I really appreciate that.

DR JACKSON: Yes.

MR BUTTON: And a good place to start in terms of kicking off around some questions, comments, etcetera. Simon, did you have anything more to add, before we begin.

MR KATTERL: No, no, take it where you please. We've got possible questions, but, really, it's your time, so – yes.

DR JACKSON: Well, you can certainly – we can have it as a two-way. We're happy to have it as a two-way street, and I know the – I think you had a presentation that you have shared. So was there anything else you wanted to add from that for the public record?

MR KATTERL: Look, just the – and this is in our submission, and we're happy to talk to this if necessary, but we were conscious of the time – is just the importance of state accountability structures. I think the productivity commission did a great job on highlighting the National Mental Health Commission and the importance of that. We highlighted some of the limitations even in the proposed national approach by the Department of Health and Aged Care from their November position paper. Crucial to implementing the agreement will mean that we have adequate accountability structures at a state and territory level. The national commission can only do so much with a kind of light-touch approach, and so the role of state and territory mental health commissions I think is crucial as well. Yes.

MR BUTTON: Absolutely. Can we start there, then, Simon, and talk a little bit about from the Queensland experience, what would that look like if we were thinking – if we're going down the path of a new agreement, we had a suicide prevention schedule in that agreement. When we think about jurisdictional governance arrangements and accountability and oversight, ideally what would that look like for Queensland?

MR KATTERL: Look, when we talk to our members – and, please, others butt in – the – or add in – the primary concern the mental health consumers in Queensland raise is that there are – there isn't really a watchdog on the – you know, on the beat, either on government or on services. So, you know, when it comes to services on the front line there's no accountability there, and, then, when it comes to government expenditure and commitments to things, that's there. So what that looks like, we're keen to keep the conversation going, but, really, part of it's oversight of government decision-making and the ability to monitor the performance of the system, and then part of it's actually monitoring how services comply with a lot of the obligations that the people have but don't enjoy.

MS ARRO: I could share an example. So a good example of where the federal, state – and we're still seeing that silos and, like, of integration is when the transitioning into the NDIS occurred, and there was federal and state psychosocial money in a past life – it's still, to this day, very disjointed, and, as a consumer, I don't give a rat's who's funding what. If I'm discharged from hospital, I – you know, I want to know what supports are there, and, you know, three months is up and then I get – you know, I've got to transfer across to the PHN-funded stuff, so that sort of stuff.

And I think with the agreement – development of the bilateral agreements was done all behind closed doors, very much just based on money and, you know, regional planning, and these regional planning processes have varied between regions in terms of the level at which people – you know, people in the community and, you know, consumers and carers are engaged in those processes. The funding with needs assessments through PHNs is often largely done by what data is available. The only data sources they have for people's experience with the system is very limited.

MR KATTERL: And just picking up one, so you've kind of – there's multiple funding streams that occur, and, really, if we had effective and consistent national – the state and territory mental health commissions that operated in conjunction with the national commission, they would be monitoring where the money's going; there would be an outcomes and performance framework at a state level, and they'd be monitoring government actions and expenditure towards that. You know, a lot of states and territories don't have, actually, an outcomes and performance framework about what the system is even meant to do, and, therefore, there's no guidance on the expenditure of money. So even a performance framework is crucial at a state and territory level.

The Commission needs to have the power to be outside of government rather than an internal agent within government, and to be able to have and open its own inquiries into matters of concern, so if there are sort of problems that are cropping up, it has the ability to do that, and it can do that at arms-length from government. Every commission has a slightly different structure. There's kind of three bags of commissions in Australia: one bag is largely advisory and holds a bit of money, and that's probably a Queensland, New South Wales and a few others. Victoria has a more accountability focussed commission, and WA has more of a purchasing kind of – type commission that purchases the services, and it's going to be difficult to filter down outcomes if we don't have some kind of consistency, but, then, also good consistency, so good commissions driving what's put into the agreement.

MR BUTTON: So that's certainly something that we have seen in looking at some of the interim recommendations around accountability structures and the role of the National Mental Health Commission and the cascading effect as you described, Simon. The issue for us at the moment is that that cascading effect is moving into different spaces, because there are different functions in jurisdictional mental health commissions where they do exist. WA is a very different one, because it's a purchaser for commission services, and others are doing different things.

I want to come back to the funding arrangement, and I'm teasing this out, because I obviously know a little bit about the Queensland system. The Better Care Together, given that there, given that there is a mental health levy that contributes to, then, effectively commissioning of services, the governance and the accountability around that, what does that look like from a lived experience perspective?

MS ARRO: My – I don't – sorry, Simon. I'm jumping in, but any – my experiences have been any sort of new money or increases of money seems to go into topping up existing, and particularly like the larger multinational. You know, I think going back to Nyoka's point around, you know, you know, local community-led, you know, decisions, and looking at community development frameworks, back to the – back to that old basic, you know, what's the issue in the community? What's – you know, what – I'm an old hippie but, you know, you know, you know, they used to call it the warm and fuzzies, but it genuinely is about in your local area, you know, what's the issues bubbling away? What's the gaps? And having resource to facilitate that building to see if it is a collective concern or gap of community, and that requires some coordination, you know, and bodies to do that.

MR BUTTON: Yes.

MS ARRO: If you think back to the old – no, I'm talking too much.

MR BUTTON: No, no, no, sorry, no, no, no.

DR JACKSON: No. No.

MS WILLIAMS-BRENNAN: I was just going to say that it is a complex area that you're talking about, but I think a PHN should get a bucket of money, and then can go away and commission their services. I question how much lived experience engagement there is in determining what those services actually are.

MS FETOA'I: Yes, I agree with that, Danie, particularly with the PHNs regionally. They're usually funding organisations based off relationships in the southeast, for a Queensland context, and they're actually not getting to understand the actual needs of what's happening on the ground and in the regions.

MS WILLIAMS-BRENNAN: Yes, I agree.

MR KATTERL: And If I pick up on – just – you sort of – there's the Better Care Together funding, and although I'm not sort of – well, I'm not across exactly what – you know, how much has gone to each particular line item, what's something – what has come through really clearly, and I suspect you can probably pick this up from the Queensland Alliance for Mental Health submission, is less than five per cent of the funding is going to the NGO sector, and this question of we want smaller and local NGOs as well getting some of this funding - - -

MS ARRO: Yes.

MR KATTERL: - - - not just the big ones, but even within that bucket, like, we're really sort of funding beds – you know, meds, beds and, you know, that's the kind of primary function of the system. And so, yes, the – if we have a plan on rebalancing the system towards more community and lived experience, and Aboriginal community-controlled services, I think that's a kind of crucial starting point, but part

of it has to, I guess, see that part of the problem is the imbalance of funding. So we're always going to have a certain parcel of money. How do we best use that in the say that's most culturally safe, rights-informed and responsive to individual needs?

MS ARRO: Yes, you also have to look too at some of – you know, whenever you have regionalised funding bodies, the – you know, and I've seen – been through where, you know, Queensland Health has gone down a regional path, and how much waste is – well, you know, how much money is actually sitting in X number of commissioning bodies, doing basically the same – you know, same administrative job of commissioning and those sorts of things. So the – you know, there – while there is a need for some regional body that I don't get they're getting the best bang for the buck, and I go back again to when they did the transitioning– we went from something like eight – no, I will get the number wrong, but lots and lots and lots of local grassroots-funded community organisations, which got stripped back to seven which were, you know, the large multinationals that didn't even have a footprint in the community at that point in time. So, yes, it's - - -

DR JACKSON: So, yes - - -

MR BUTTON: Just on that point Paula. funding transparency there.

MS ARRO: Yes, yes, yes.

MR BUTTON: ..... to at least start the process, so that community gets an understanding of - - -

MS ARRO: Yes.

MR BUTTON: - - - where money's going, and who's delivering services.

MS ARRO: Yes, and the KPIs, and the tender documents. So, you know, we're starting to see a bit more of, you know, demonstrated consumer and carer engagement, and – or, you know, First Nation and things like that. There may be a KPI in there, you know, you know, "Did you do some engagement or co-design?" but it's not actually – you know, what if they haven't, you know? There's - - -

MR KATTERL: Yes.

MS ARRO: Yes. So - - -

MR BUTTON: Well, just picking up on that. That goes again to the – like, if you've got the – if you've got a – the current system is, you've got a funder and then you've got a provider, and the KPIs exist with them, but there needs to be a third-party accountability structure, you know? Otherwise, you know – you know, governments obviously want to manage systems effectively, but if it's a tight feedback loop between the service provider and the service funder, there's really not much wriggle room or leverage for us to get outcomes. And so we need something

that sits outside of that. You know, whether that's a commission, whether that's something else, we need some accountability structures to make sure that those things take place that are – even if they are written down as KPIs.

MS ARRO: Yes, and - - -

MS FETOA'I: But they need to be lived experience-led as well. Sorry to cut - - -

MS ARRO: Absolutely.

MS FETOA'I: - - - in there, Paula.

MS ARRO: Absolutely.

MS FETOA'I: Yes.

MS ARRO: Well, being in a previous identified lived experience role, I used to go around cap in hand, you know, around February-March, "Anyone got any underspend, so we can do stuff in lived experience?". So, you know, that – that sort of transparency too with underspend, and it just – you know, it's going off quietly to top something up.

MS WILLIAMS-BRENNAN: Absolutely.

MS ARRO: Yes.

MS WILLIAMS-BRENNAN: I worked at a PHN, and I certainly saw that going off quietly to, you know, other projects or, you know, the sister projects, and it was disheartening, to say the least.

MS ARRO: There were some – there was initially when the responsibility for federal commissioning went – was handed to the PHNs where there was, like, some lead site funding, and there were some real pockets of brilliance that came out of that. We don't have time today, but in the perinatal peer support space, you know, pilot program there. Now, if you want to talk prevention, early intervention, having that support while pregnant for mums and bubs, and dads, and families, and local communities, you imagine the long-term effect if there's that support at that point in time, and that was an example of pilot funding, which then was taken up by State government and, you know – but that's not always the case. So there's some good pockets of stuff happening around the world – around Australia with pilot money, but – and being evaluated as being a good thing, but then not replicated. So there's some good.

MR BUTTON: Okay. This sort of goes to my next question ..... good segue, because I was going to ask about some of the things that you've seen where lived experience are very much involved in the design, and the implementation and, obviously, the oversight and accountability. Are there some examples in your

jurisdiction where things are working well, and that you can point to and say, "Look, here's a good model because of all of these design elements that have gone into it".

MS ARRO: Simon, did you want to – or - - -

MS WILLIAMS-BRENNAN: I can .....

MS ARRO: Nyoka?

MS WILLIAMS-BRENNAN: Yes, no.

MS ARRO: .....

MS WILLIAMS-BRENNAN: I can, Paula.

MS ARRO: Go, Danie.

MS FETOA'I: Thanks, Danie.

MS WILLIAMS-BRENNAN: Yes. I think of safe spaces, community-led, it's peer workers assisting people in emotional distress, operating out of independent housing, whether it's a building or an actual house, and it's there to give an alternative to people to presenting at the ED department, when they're in severe emotional distress. If I look at the safe spaces, particularly the one run by Neami National in Strathpine. Fabulous group of people on the ground who perform over and above their duties to anyone who walks in the door. They have terrific feedback as a result, and I've known quite a few people who have accessed the service as a result of its reputation.

MS ARRO: Yes, but you know what they've done, Danie, just recently? The funding, again, is – they've changed the funding, and they used to be open from 3 until 8 pm, so there was time to – you know, that bit of opportunity to do warm referrals and things like that with other services that were already open, and close at 5.

MS WILLIAMS-BRENNAN: Yes.

MS ARRO: The funding has been reduced so that they're now open 4.30 to 8. So, again, that funding decision - - -

MS WILLIAMS-BRENNAN: Yes.

MS ARRO: - - - has ..... up the whole intent of that, you know, being able to go somewhere in an acute state at that point in time, be able to have a warm referral to – you know, so they're – people leave knowing that there's – they've got somewhere to go to tomorrow, and that sort of thing.

MS WILLIAMS-BRENNAN: Yes.

MS ARRO: And these decisions weren't made – but you know, there was no - - -

MS WILLIAMS-BRENNAN: Consultation.

MS ARRO: - - - community consultation around that - - -

MS WILLIAMS-BRENNAN: Yes.

MS ARRO: - - - and it has only recently just happened. Very frustrating.

MS WILLIAMS-BRENNAN: Yes. Thanks for that. I haven't heard about that.

MS ARRO: No, I only heard this week. I - - -

MS WILLIAMS-BRENNAN: .....

MS ARRO: Very grumpy old lady, I was.

DR JACKSON: ..... Anyway, we can't comment too much about specifics, I note that it's not a lot of money involved in running these services for the outcomes.

MS ARRO: Yes.

DR JACKSON: We are at time, but I want to make sure if there's anything that hasn't been said, or anything you would like to add. Obviously, we have submission and the – I'm not sure. Will the presentation be publicly available, or - - -

MS FETOA'I: It's up to them.

DR JACKSON: It's up to .....

MR KATTERL: Yes, I mean - - -

MS ARRO: Yes, yes.

MS FETOA'I: Yes, I - - -

MR KATTERL: Yes, yes.

MR BUTTON: Well, that's certainly a question for us, that not only will we add it to the transcript, but we will also make it publicly available, so that others can see it as well, and if you're okay – with your consent, we could do that.

MS ARRO: Yes. Just one final thing, just because I'm a chatty person, but I just would like to reinforce, you know, that not – you know, the Commission really taking a look – close look at that State and territory stuff, because they – as well as the federal, you know, National Mental Health Commission stuff. You know, State and

territory have regulatory responsibilities for, you know, the harms that we're seeing, you know, within hospital and health services. They've also – there's different industrial relations involved when we're talking about, like, the lived experience workforce, for example, you know? So there's a number of roles, you know, outside of specific mental health that the State have responsibility for in terms of social determinants of health. So - - -

DR JACKSON: Definitely.

MR KATTERL: Nyoka, did you – you had one thing to say, I thought.

MS ARRO: Sorry.

MS FETOA'I: Yes, I just wanted to just – you asked before about things that may be working. In terms of central Queensland, we have Murri Binda at the moment where there's seven Aboriginal and Torres Strait Islander organisations involved in a collective, where what we wanted a request from funders is that, come and have a yarn with us as a collective, and we sort of discuss where best place, you know, funding is to go when it comes to Aboriginal and Torres Strait Islander people. So as they build on that, we're still trying to get our local ACCHO on board, but I think in terms of federal, you also have the SPSP, which is the Stronger Places, Stronger People funding, which is supposed to do the – pretty much that, right? It's to say this is where best – funding should go, and how it should be distributed, but I think, like, for First Nations people, where people are – organisations are willing to work collectively, you're going to get better outcomes for mob - - -

MS ARRO: Absolutely.

MS FETOA'I: - - - than you are where there's standalones.

MS ARRO: Absolutely.

MS FETOA'I: That's all I've – yes.

MS ARRO: Yes.

DR JACKSON: Thank you. Yes, it's - - -

MS WILLIAMS-BRENNAN: Yes.

DR JACKSON: I think it's a point that we can probably make a bit strongly. And so that's, yes, good to have that .....

MR BUTTON: Really appreciate your time this afternoon. Thank you very much for your submission, and for your participation, and hopefully we will be able to report back with something in October that starts to reflect the types of things that we've talked about here today. Very, very conscious of making sure that whatever

we're recommending at a national level, does have a flow on effect to make sure the jurisdictions are doing their bit as well. So thank you very much for offering that to us.

MS ARRO: No, thank you for the opportunity.

MR KATTERL: Thank you, Commissioners.

MR KATTERL: Yes, thank you.

MS ARRO: Thank you.

MR BUTTON: That concludes the scheduled public hearings for today. Before I formally close proceedings, I should check to make sure if there's anyone who wants to appear today before the Commission, please use reactions to raise your hand. I think it's ..... on.

DR JACKSON: Yes.

MR BUTTON: So with that, I now adjourn today's proceedings until tomorrow.

DR JACKSON: Thank you very much.

MR BUTTON: The next hearing will be held online. We're starting tomorrow and at 1 pm.

DR JACKSON: We've pushed it back.

MR BUTTON: Thank you.

DR JACKSON: Ending it now. Thanks, team.

MATTER ADJOURNED at 4.34 pm UNTIL THURSDAY, 21 AUGUST 2025