

Review of the National Mental Health and Suicide Prevention Agreement

TRANSCRIPT OF PROCEEDINGS

O/N H-2045721

PRODUCTIVITY COMMISSION PUBLIC HEARING

**MR SELWYN BUTTON, Commissioner
DR ANGELA JACKSON, Commissioner**

DAY THREE

THURSDAY, 21 AUGUST 2025

MR BUTTON: Good morning, and welcome to the final day of public hearings for the Productivity Commission's review of the National Mental Health and Suicide Prevention Agreement. I would like to begin by acknowledging the traditional custodians of the lands that we're meeting on today and we're broadcasting from.

5 Today, we're in Canberra, Ngunnawal Country, and I would like to pay respects to their custodianship and Elders here on this country and where everyone else is located around the place as well. So my name is Selwyn Button, and I'm a commissioner with the Productivity Commission.

10 Today, with my fellow commissioner Angela Jackson, we're leading this public inquiry. The purpose of these hearings is to facilitate public feedback and comment on the recommendations and findings that we made in our interim report, which was released in June. Following our public hearings, we will be working to finalise the report and hand it to government in October, having considered all the evidence that
15 has been presented at the hearings, the submissions that we receive in relation to the interim report and further analysis undertaken for this 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.

20 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 the participants that sessions are being recorded, and a full transcript is being taken. For this reason,
25 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 as well.

30 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
35 the team can see, or you can email the address provided in the Q and A. We wish to advise that this viewing 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, and for those who are presenting, there will be a bit of a delay when
40 we do that as well.

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
45 who can provide them with further information. Participants should be aware that media representatives present may also use social media and other internet

mechanisms to convey information online in real time, including participants' remarks. We have a counsellor, Natasha Belmont, from Relationships Australia Victoria with us today for anyone who would like to chat or needs some additional support. 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 break-out room with Natasha after their appearance has concluded. I would now like to welcome the team, our first presenters for the day, which is the team from the Liptember Foundation, and I think we have Katrina and Luke who are going to present today.

MS LOCANDRO: Hello.

MR BUTTON: How are you Katrina? Can you hear us okay?

MS LOCANDRO: Hi. Good thank you. How are you guys?

MR BUTTON: Good. Good. Have we got Luke as well.

MS LOCANDRO: Yes.

MR MORRIS: Thank you, guys. Just introducing ourselves, I'm Luke Morris, CEO and founder of the Liptember Foundation, the peak consumer body focused on research, advocacy, education, awareness for women's mental health.

MS LOCANDRO: All good. I'm Katrina. I'm head of strategy operations and the research lead here at Liptember Foundation, and I'm here on behalf of the women of Australia who, I guess, share their views with us and their experiences with their current mental health system, but also I'm a consumer of mental health services with lived and living experience. So, further to that, I thought it would be good to provide our opening statement if that works for you guys.

MR BUTTON: Yes. More than happy for you guys to move into the opening statement, and then, post that, we will throw a few questions and get into some other pieces as well. But happy to hand over to you to undertake the opening statement.

5 MS LOCANDRO: Fantastic. Well, firstly, as Luke said, thank you so much, Commissioners, for the opportunity to appear today. We definitely want to acknowledge and agree with the interim report's recognition of the fragmentation and inequity across Australia's mental health system at the moment, and our submission definitely explored a range of further recommendations that we have to
10 improve the agreement when it comes to the needs of women and their mental health. However, in our appearance today, we definitely want to focus on one of the more pressing recommendations that we made, and so that main concern is really around gender responsiveness and the fact that it's absent from both the current agreement and the interim report.

15 So to touch on it, our submissions outlined evidence from our 2025 research report, which is titled Beyond the Surface, and this research gathers the voices of over 7000 women and gender diverse people across Australia, and so, because of that, it delivers nationally representative and statistically significant findings that have been
20 made really clear to us, and what it's saying that women are really being let down by a system that is not designed for them. And so, currently, one in two women in Australia are experiencing mental health issues and one of four – one in four women are facing a severe mental health issue. And, critically, I think the reasons this is important to mention is the fact that these statistics really haven't shifted since we
25 began our annual research back in 2022, and I think it's something that we really want to pause and reflect on because mental health is not something that is experienced in a vacuum, and for women, it's shaped by such a complex web of reproductive health challenges, financial stress, unpaid care responsibilities, structural discrimination experiences and also experiences in things like
30 gender-based violence and, you know, still societal stigma that surrounds mental health, and these kind of key drivers are unique, intersectional and require a really tailored approach when it comes to mental health care, and yet what we've seen in the agreement is that it's currently gender blind, and gender is not even really mentioned in that agreement.

35 So we're standing here today because we want to showcase that one-size-fits-all model is no longer something that's acceptable and delivers really good outcomes. So what we want is a gender-responsive lens because otherwise any reforms made from this agreement really just run the risk of reproducing the very same inequities
40 that we're all seeking to solve, I guess.

So we also thought it was important to highlight in this opening address that there are some current accessibility issues for women who are currently seeking support in our mental health care system. They're experiencing things like long wait times, high
45 out of pocket costs for support, and inflexible support formats. So we really see an investment in bulk-billed and telehealth models, as well as expanding the regulated mental health workforce to include key workers and counsellors as probably a

great start in broadening that accessibility to meet demand because these roles really play a vital but currently undervalued role in women's support networks. And I guess, finally, in order to truly do better, we need to know better, so that means everything being backed by evidence and data.

5

So the research we undertake as the Liptember Foundation really just tells us one part of the picture, but this agreement must also track the sex and gender disaggregated data to make sure that we're strengthening prevention strategies and measuring the effectiveness of support services and programs as they happen. And so that's why we, as the Liptember Foundation, are calling for a gender responsive schedule to be embedded within the agreement, and so that's something that's co-designed, which is really important with people with lived experience of mental health issues, consumers of the mental health system, as well as consumer groups like Liptember Foundation who really represent the voices of women, lived experience, advocates, and those from other priority population groups.

15

So this schedule that we're proposing must then also be backed by investments in that holistic kind of wraparound mental health care that can see people as a whole with mental and physical health intertwined, investments to integrate gender-specific mental health supports alongside physical health services, especially during key life transitions that women face, such as puberty, pregnancy, motherhood, menopause is also really critical and quite low-hanging fruit. So we believe that reform is possible, but it really, in order to be successful, needs to centre around those lived realities that women are experiencing at the moment.

25

And the team here, we're fully behind collaborating with government and service providers to really build that mental health system that is equitable, inclusive and, I guess, gender responsive by design, and we know that the Productivity Commission is tasked now with holistically considering and assessing and making recommendations on the effectiveness of reforms to achieve the objectives and outcomes of this national agreement, and part of that includes across different communities and populations. So I guess to finish, we would really love to invite some open dialogue with yourselves, commissioners, and input around whether a gender responsive schedule would be included in your recommendations for the final agreement going forward. Thank you.

35

DR JACKSON: Thank you. Luke, did you have anything or did you = are you - - -

40

MR MORRIS: No, she has done a good job there. She has covered it all.

45

DR JACKSON: Yes. No, I thought that – I wasn't not going to not let you have your opportunity. Look, thank you, and I think highlighting, like, the specific issues in the system and the way in which the Commonwealth and the States are working is impacting on women and men differently, and that gender-responsive approach is, you know, it's good policy, effectively, like, because, you know, you don't get the outcomes by treating sort of the average across the two. You get by actually addressing people's needs. So I think, you know, from our perspective

anyway, it's good to have that feedback in terms of what sort of gender lens are we doing on all our work, rather than it being something that we just tend to focus on when it's a woman's issue and it's - - -

5 MS LOCANDRO: Yes.

DR JACKSON: - - - rather than actually looking at these issues. So, first of all, thank you for that. I think that's really good feedback for us to take as we do the final. I guess on the schedule, that said, the way in which these national agreements work – and this is where you get quite technical, and it all gets a bit bureaucratic – is it's really around what governance and reporting framework. So it's not so much saying if it doesn't have a schedule it's not included. So things, and initiatives can be included in the main body of the agreement, and, in fact, I would say gender should be across the agreement rather than being, again, that specific focus. That it should have that gender lens applied across it, rather than having one schedule that deals with it, and then it comes down to what's the governance framework around that? So, effectively, above each of the schedules that we've currently proposed, and potentially an additional one on alcohol and other drugs that we're still consulting on, there needs to be a governance framework sitting above that that provides that accountability, which in this phase might be a little bit more difficult in terms of what would that even look like. And then we want to make sure that, yes, alcohol and other drugs, for example, has a gender lens, you know - - -

MS LOCANDRO: Absolutely.

DR JACKSON: - - - to those issues. So I think – so that's just to give you a bit of a – and not to say no. I get what you're saying, but the – it's not to say gender shouldn't be part of this agreement and shouldn't inform the way in which the agreement itself is drafted and informed, but it's just where and how there can be some sort of, you know, bureaucratic – a different – different approaches in terms of the actual operation of the agreement.

MS LOCANDRO: Yes, absolutely. And I think that's where co-design is really essential when it comes to building those frameworks and understanding what it is that women need in their services, and not just women. Like, having a gendered lens applied to the agreement benefits everybody in terms of our male counterparts, gender diverse individuals, and, I guess, having their needs in mind and making sure that there's accountability mechanisms there and data collection, that sex and gender disaggregated is really important to understand whether or not what is being proposed is working and is actually meeting the needs of each of those cohorts, and so whether or not it's a new agreement – sorry – a new schedule, obviously, that's what we would prefer, but if it's kept in – across the agreement and made sure that it's a priority across everything that we do and undertake, then it cannot be forgotten, and it cannot be underrepresented to meet the needs of each of these different cohorts, and I think, under the current agreement, there's a priority population groups listed and, you know, of that, it gets quite specific, and I think really, at a very bare minimum, at least women should be represented there because I think a lot of their needs and their

high access with the health system would really – they would benefit by having this really kind of connected approach to their whole selves, to be able to integrate their physical wellbeing with their mental and there's so many opportunities to do that across the board.

5

MR BUTTON: One of the ways, I guess, that you highlight in your submission as well, Katrina and Luke, that would be good to tease out, which is something that we're certainly keen to get some more perspectives on is around accountability and reporting, and you've highlighted about data disaggregation down to gender-specific data disaggregation as one of those ways, and that's certainly something that we would – we're supportive of because there is, at the moment, as you would have seen in our interim report, there is a lack of, I guess, data that's available to the public to then understand the impact of the services and initiatives that are being implemented as part of the National Mental Health and Suicide Prevention Agreement. So if we're focusing on the accountability component of ensuring that those funded services and funded activities that sit under the agreement are, I guess, are addressing the needs of the entire community, and then we have data disaggregation down to gender specific within that. Could that be a way of ensuring that we've got some greater accountability of services and what's happening through the agreement?

20

MS LOCANDRO: Yes. We – we're definitely in support of that, and I think in terms of some of the information you are seeking around public dashboards and things like that, absolutely. We, as an organisation, support that. But at that useful data, and then it has got the sex and gender components in there at the moment when it's built because that's really what's going to provide clarity around whether or not services are effective, whether there's uptake of services, whether women are getting the outcomes that they need and/or anybody that is using the mental health system is getting the outcomes that they are seeking. So yes, with this clarity, data will provide a lot more opportunity for making the right recommendations, the right funding decisions, the right service provisions, all of those things.

30

MR MORRIS: That's why I think also our data is really important too, like, circling back onto the additional schedule with substance abuse, and that was a really big theme in our 2025 research, and, you know, compared to the general female population of women with mental health issues suffering with substance use disorders, you know, we saw that women facing poverty or homelessness were at rates more than double. Indigenous women and LGBTQA+ women were nearly double as well, and then also women with a disability were at one and a-half times higher. So that's, I think, where our data is really valuable as well, from a, you know, placing that sex and gendered lens on top of mental health.

40

MR BUTTON: And certainly, I mean, I use the – I often use this. – I guess the example of the Closing the Gap data dashboard that we've got sitting on our Productivity Commission website.

45

MR MORRIS: Yes.

MR BUTTON: Not to say that we need to have – we should be hosting it on our website, but it gives, I guess, a framework of what it could – what it possibly could look like for the dashboards because this Closing the Gap dashboard contains not only government information but also community-based data, as well as survey
5 data from other sources, that provide additional context. And so it's not just the data and the figures, it's some of the stories behind the data, so that people get an understanding of some of those causal effects between certain pieces in society that actually contribute to the outcome as well. So they're the sorts of things that we would be thinking about in terms of the overall public accountability and reporting
10 process, is how do we actually paint a picture for the public to get a better understanding of how the entire system is working and their interface with it.

MS LOCANDRO: Yes.

15 MR MORRIS: Definitely.

DR JACKSON: Yes. No, it's – yes. And, look, and particularly the gender aspects of this are pretty profound, as you're aware of, and the differences across a number of metrics – the gender-based differences are stark, and probably it's worth
20 highlighting, and this so I note to the team, in our final report, that difference also with the general indicators where there are gender differences as well, obviously but, you know, it's hard to think about, particularly if you think about young women, for example, and some of the, you know, distress figures, self-harm figures, like, it's very stark in this area. So I think highlighting that, thank you. And if you haven't
25 already, we would love to, I'm sure, receive the data that you have and the information.

MS LOCANDRO: Yes.

30 DR JACKSON: And the submission.

MS LOCANDRO: Yes. We would definitely love to further provide more evidence in that respect from our research, and I think I just want to touch on what you mentioned about young women because what we found in this research is that
35 women really face, like, heightened mental health risks across different life stages, depending on where they're at in their life, and puberty, pregnancy, motherhood and menopause, like, that came up consistently as really key triggering life points that have a really big role to play with a woman's mental health and how they're coping. And so I guess, you know, our research showed that 74 per cent of young women
40 who were going through puberty this year with a mental health issue were also dealing with body image issues, right, and these issues resulted in those young women experiencing higher rates of eating disorders compared to the general female population.

45 And we also know that the – from this year's research, that two in five women who experience physical birth trauma, for instance, were experiencing PTSD this year, and that's more than two times higher than women in the general female population

who weren't – who didn't experience birth trauma. So this, I guess, link between physical and mental health and life stage being so – so interlinked is really, like, an opportunity for us as a society to meet women where they are and meet them where they're accessing services and support, and it really makes clear that, I guess, mental
5 health prevention programs and support services need to be integrated with these physical health services and other adjacent systems because, at the moment, it's not consistent around Australia, and that, you know, with that, it means it's just not equitable, right.

10 And so, I guess, in perinatal mental health screening, for instance, across public and private hospital settings for expectant mothers, that's one other area, so that's completely inconsistent regardless – depending on what hospital system you choose, whether you're in the private system, the public system, and the mental health care aspect of that woman and that new mother is inconsistent at best. So trying to really
15 link those services and make sure women are supported when they're already accessing support through the health care system and making sure that it has then got that layer of mental health is really important. And, I guess, that's where we figured the mental – sorry – the gender-responsive mental health prevention intervention programs, like screening tools, could really help support women in this process and
20 get better mental health outcomes overall for all genders. So doing this in any gender.

MR BUTTON: And I guess it leads to a question from me, Katrina, in that space because what we're wanting to be able to do as part of our process is not just go back
25 to government to recommend to say, Here are the things that we think in terms of bold recommendations around new agreements, new strategy", etcetera, but also then point to where the evidence suggests that these things are currently working, and I guess that goes to my question for you guys is do we then have pockets of evidence and some research that you – I know you've done – undertaken a survey to identify
30 some of the gaps in the system, but then do we have also the evidence that suggests that these are the things that are seen to work in the system, that look at improvements, that we can also provide as part of our process as well.

MS LOCANDRO: Yes, and it's a great question, and I think it's a question that
35 needs proper investigation and funding to be able to find out, right, because it has not been done necessarily across the board, and it's something that's very niche in certain pockets of our country, and so we're not necessarily across every single service that's out there, and I think that there needs to – we would love to do a, I guess, an exploration exercise in making sure that we can find out what is working
40 and what's not from an individual service provider point of view, but I guess, from a more generalist point of view, knowing that the government is looking at rolling out endometriosis clinics and menopause GP consultations, those types of things, we know that that's on the agenda. So how do we make sure that when these things are rolled out that they have a mental health component added to them, and it's not just
45 an afterthought.

So from our point of view, we know that women who are suffering from endometriosis, for instance, as a physical health condition are suffering rates of mental illness at higher rates than those who aren't. And so how do we make sure that these clinics not only meet those women's needs from a physical health
5 perspective but also make sure that we're catering for their mental health needs at the same time, because if we can get on the front foot and be preventive with this stuff, we're not going to see those women, hopefully, accessing the crisis support services that are available at the moment. How do we stop women falling into the crisis support section and get really on the front foot with preventative mental health care
10 when they're already seeking support for their physical health because that's usually the thing that comes first. So I think that, to kind of answer your question on a more broad scale, is tapping into the plans that the government already has in those spaces and making sure that mental health is a priority there from a preventative lens.

15 MR BUTTON: That's a good point. And then thinking more broadly about – and certainly that's – that is something that we're sort of grappling with, and it would be good to get some thoughts from yourselves as well in relation to that cross-portfolio component of the agreement where this is – a lot of the work that we're talking about in this space isn't exclusively in health, that it does require a range of the support and
20 an example in housing, in education, in justice.

MS LOCANDRO: Yes.

MR BUTTON: How does – where do you see those sorts of things, or what – how
25 do you – are there some thoughts about how do we make sure we're influencing – able to influence those cross-portfolio measures as well?

MS LOCANDRO: We would 100 per cent support a cross-portfolio integration of mental health services, especially with that gendered approach, because we know
30 domestic violence services and housing, that is just as important as some of the physical health aspects. I think where we come from is that we've still got so much work to do just in the really easy things we can implement, which is the physical health space, but it obviously needs to be integrated across all aspects of our system because that's where women are inherently using all of those services across our
35 support network, and we need to be making sure that mental health services are provided as part of that, also from a preventative lens. So we would definitely welcome collaboration to help work on that with you to make sure that we can suggest the best things going forward.

40 MR BUTTON: Yes. And something that has come up, and I'm not trying to lead you to answering questions here or anything like that at all, Katrina, but – don't think that I'm trying to walk you down a certain path, but we have heard from certainly others that have appeared at the public hearings that talked about the need within the next agreement to – for a specific focus on research and evaluation. We talk – in the
45 interim report, we describe, I guess, research and evaluation in the sense that there needs to be a greater, I guess, acceptability of information around research and evaluation, and when evaluations are done, we're suggesting that they need to be

publicly available, so that people can know that there's evidence attached to the initiatives that are being funded under the agreement, etcetera, but I guess wanted to get your thoughts on do we need to call out research and evaluation in the next agreement as something that's important to build – to continue to build the evidence base?

MS LOCANDRO: I think that there's a lot of research being done generally speaking in mental health, but there's not enough funding in research that is around the gendered aspects of mental health and I guess the relationship that hormones play in mental health outcomes for women and vice versa. There's – there is definitely a very big need for research in that clinical academic space that covers gender-related mental health issues because there's not enough research out there that's sex and gender disaggregated, and we know from that our work with the – the great team at the George Institute.

So what we would like to see is obviously a commitment to furthering research by gender in the mental health space, but, secondly to that, I would also really [indistinct] research that is not just clinical and academic, and lived experience research and the voices of consumers that are using the mental health system are just as valid as this clinical and academic research is, and I think that that it needs to be a balanced approach and we take that approach at the Liptember Foundation. We invest in clinical and academic research but we also invest in the lived experience research and that to us is really important because it provides that holistic evidence base to really make the correct decisions when it comes to funding and policy and evaluation of services and plan works. So we would really encourage that there's probably something put into that suggestion around the voices of lived experience research as well, being a part of that investment.

MR MORRIS: And that's what we identified when we did start our research, is that there was a gap there, and I think that's a real strength of our research as well, is that it's timely. It's an annual research that we release, and it's – you know, it may not be clinical and academical – academic, sorry – it's a voice of Australian women and it's really, really powerful through that lived experience lens to get a real understanding of the landscape of women's mental health in, you know, in a timely manner. So that's something that we went and identified and, as a foundation, funded ourselves, and it has gone from strength to strength, and it's growing, and we are collaborating with many different peak bodies within that – within the physical health space as well and that interplay between the two, which we're discovering is just incredibly significant in the impact it places on women's mental health. So, you know, we're seeing that grow and grow year on year, and we're really excited of where that's going because we're now able to retrospectively have comparison data and see trends and how that's tracking. So it's become an incredibly insightful tool for us and the wider industry, and it also helps us deliver further impact in the space by, you know, giving us evidence-based informed impact based on data.

DR JACKSON: Now, we could go on. This is one of my favourite topics as you may have noticed. So we could definitely go on, and – but thank you very much for

your time. Sorry, we have to run to a pretty tight schedule today as you probably understand.

MR MORRIS: Of course.

5

DR JACKSON: Thank you, and for all your work in this space. It's, you know, obviously critically important, and thank you for your contribution to the inquiry so far and your evidence today.

10 MR MORRIS: Thank you very much. We really appreciate your time.

MS LOCANDRO: Thank you.

15 DR JACKSON: We look forward to continuing the conversation. So thank you. Thanks.

MR MORRIS: Thank you.

20 DR JACKSON: So next we have the PHN Cooperative a team. Phillip Amos and Amanda Proposch

MS PROPOSCH: Hi. How are you?

25 DR JACKSON: Good afternoon.

MR BUTTON: Hi.

30 MS PROPOSCH: Well, thank you. Yes. Amanda Proposch. I'm from Gippsland PHN but representing the national PHN Cooperative, a working group of 30 PHNs across the country, yes.

MR BUTTON: Excellent.

35 DR JACKSON: Fantastic. Thank you for your time today.

40 MR AMOS: Hi. I'm Phil Amos. I'm the national policy and capacity building manager for the PHN Cooperative. So I work across all 30 PHNs and focus on, yes, national issues, collaboration across primary health networks, and worked on the submissions that have been made to the Productivity Commission for this review.

MR BUTTON: How are you both today?

45 MS PROPOSCH: Really well, thank you. Thanks for having us and the opportunity.

MR BUTTON: Look, not a problem at all. What we will do is allow you to provide your opening statement, the things that you want to focus on today in your presentation, and then we can go to questions. How does that sound?

5 MS PROPOSCH: Sounds good.

MR AMOS: So we suggested three topics.

MR BUTTON: Yes.

10

MR AMOS: Those being, firstly, draft recommendation 4.1.2, which directly talks to funding to support primary health networks, meet local needs. Secondly the recommendation about psychosocial supports outside the NDIS. And, thirdly, for 4.6, around the transparency and effectiveness of governance arrangements. So to start with the first one, which is 4.2 about funding to support primary health networks to meet local needs, so we are – we support this recommendation, and we certainly support the recommendations beside this that would create a positive, you know, enabling environment for PHNs to meet local needs. This has been a key challenge for us under the current architecture of the governance and the operating environment that the current agreement has created.

20

Probably be useful to, I guess, share some of the insight of what we've reflected from the interim report in terms of how this recommendation could be implemented or achieved, and, firstly, the key point for us is the need to bridge the gap between the high-level policy intent of the agreement and then the realities of regional implementation. I know you've heard from some other primary health networks that have come to you individually as part of this as well. But foundational for us is the need for the parties to the agreement to come together and articulate those national mental health and suicide prevention purpose and priorities that are then implementable and measurable at the regional level. So under the current agreement that was a, you know, a struggle for PHNs to respond to the lack of clarity around those areas in the agreement, and having those clear expectations will certainly provide a foundational context for PHNs to respond with the sort of locally aligned decision-making and implementation that the Productivity Commission is calling for. So we're certainly very supportive of those recommendations around governance reform and the improvements to the structure to connect up the high-level intent with the reality of working at that regional level.

25

30

35

We wanted to suggest some of the systems and practices that we think are needed to bridge that gap to enable that systemic collaboration that the PC is looking for at the regional level. Certainly, we think primary health networks are – can be ideal incubators and enablers of the sort of local innovation and best practice that's called for in the interim report, but there certainly are some gaps in terms of the supporting architecture that would enable us to do that. So we do have limited systems at the moment around quality improvement, sharing of evidence, and insights into what works, where and why at the regional level, and I know hearing some of the discussion from the last speaker, we're certainly also in favour of opportunities to put

40

45

in place some of those enabling pieces. So the joint regional planning guidelines, the Commission has called for release of those, and we see those as useful. But I think, more broadly, joint regional planning is not treated as a systemically important or impactful activity under the current agreement, so we're certainly looking for
5 advance in that area that can give the impetus and support for joint regional planning and commissioning to make it more effective.

Another example that we call for is a national repository of evidence. We've talked about a "what-works" network, and this is modelled on similar examples in the
10 United Kingdom and so on in that previous discussion. I know you were talking about how to scale and share evidence. Look, for primary health networks, when we go to design and commission, now, the nature of the current structure is we do have to do a lot of that in each of the primary health networks, you know. It is an individual exercise. We do share where we can, but an example of this what-works
15 network would be some national infrastructure that would build and translate research and evidence into the implementation of the agreement. That would certainly help PHNs to know what is working where, and it could certainly link into the data and reporting structures that you talk about to raise the quality of efforts across mental health and suicide prevention nationally.

20 We are doing some work within the cooperative in terms of sharing information around internal benchmarking, so this is not publicly available, but PHNs do need to be able to see how other PHNs are performing across programs, so we have started some work around that where we are pooling and sharing data. That work is still
25 relatively nascent. It's in the early stages, but there are opportunities to link that, get the endorsement and alignment with the department, AHW and others to improve that area.

And I will just comment on the – under that recommendation just around the call to
30 standardised procurement and data-collection processes. We just want to note that this is an area of ongoing work between primary health networks and the department at the moment. There's multiple reviews around primary health networks looking at business model, flexible funding and the clinical review, looking at ways to standardise, improve some of those processes. We certainly think that there are
35 issues around standardisation and some of the impacts that has on cost in the sector. We do think that probably proficiency and procurement is a better way to frame this, noting that one of the under-recognised parts of PHN role is around market development. So we do do a lot of work developing providers and markets in our region. It's not always amenable to a standardised procurement process because we
40 do need to bring providers together, create partnerships and scale up models but we do think there certainly are some other opportunities where we could work together with the department and others to look at those.

I might just pause there. I'm not sure if you want me to go through all three of those
45 topics, or you want me to pause after each one for some discussion.

DR JACKSON: I would like to pause, but I think just – for time-management purposes, it's going to be better if you go through and you've got everything on the record, and then we can come back and [indistinct].

5 MR BUTTON: Yes. We don't want to lose your opportunity to make sure you're getting it out.

DR JACKSON: Yes, we don't want to rush you. Yes. Yes.

10 MR AMOS: So the second one is around the recommendation 4.4 to address the unmet need for psychosocial supports. Look, we are strong supporters of the need for a response to that unmet need that has been identified and measured now. The point we wanted to make about this is that the current recommendation calls for State and Territories to be responsible for commissioning the services. From our
15 perspective, I guess it does overlook the role that PHNs play as the current commissioners of the Commonwealth psychosocial support program. So we are and have been historically commissioners of psychosocial supports, and the program we have is one of the legacy ones that still exists that didn't disappear into the NDIS, and we want to note there is a significant opportunity there for the Commonwealth to
20 use that existing architecture, the relationships and contracts PHNs already have with psychosocial providers with services that are integrated at the regional level.

So we are integrating those psychosocial supports next to the clinical programs that we commission, next to suicide prevention programs, AOD programs. We think it
25 would be a tremendous loss if those new psychosocial supports only went through the states. We can do that rapidly. We can do that really efficiently through those existing relationships, and, as I said, it really accords, I think, with what the Productivity Commission is calling for, in terms of integrated holistic model. So we are doing that, and we wanted to call that out in terms of that recommendation 4.4.

30 And just to touch on 4.6 around transparency and effectiveness of governance arrangements, again, very strongly supportive of this, and governance has been a particular challenge for primary health networks in the current agreement. What we're seeking is greater recognition of our role within this agreement. We have a
35 great number of responsibilities and roles in terms of delivery and implementation. We don't think that has been reflected in the operation of the current governance environment, and that has made our role harder. So, in particular, what we want to have is clear structures which engage both the parties, as well as those other actors, in the agreement. PHNs, LHNs, people with lived and living experience, to bring
40 them more formally into these processes.

One of the examples here is that PHNs had very limited engagement in implementation planning that occurred. So there were some PHNs leaders who were able to observe of some that process, but, by and large, despite our role in being one
45 of the primary implementers of the agreement in terms of the program activities, it was very challenging to have such limited engagement in those governance processes. And secondly, also, just to point out, we had a similar experience around

the development of the national joint regional planning guidelines, so these were not delivered through the agreements, and principles were delivered later, but I do think it's notable that PHNs were never formally engaged in discussions around joint regional planning guidelines. You know, this is our core business. It's our core
5 function. It may be that just those discussions never got to the point of actually talking about how to develop those guidelines, but we were completely outside of that process, and I think it's notable when you look at the national architecture as it is at the moment, planning and commissioning are almost invisible in that architecture. There's data groups; there's evaluation groups; there's other places that have some
10 formality in there. But, you know, we really think that there needs to be an elevation of those planning and commissioning functions to be recognised within the governance of this agreement, and that would substantially improve, we think, what PHNs can deliver under the next agreement.

15 MR BUTTON: Amanda, did you want to add to that?

MS PROPOSCH: You've articulated it really well, I think. At the heart of every element that we've raised today is a real desire for improved, I guess, collaboration, strengthening regional governance, that joint planning, and clarifying
20 roles and responsibilities, so we really are working together. We have found the PHNs are really embedded in each of our respective communities. The last 10 years we've been working with the service system, consumers and providers, commissioning building capacity, coordinating the delivery of care, really targeting areas where there's fragmentation, and I think it's the – a key going forward is just a
25 better joint collaborative way forward. So we're, you know, what has created silos potentially from states and territories outside of the PHNs can come together and really optimise these resources. Yes.

MR BUTTON: Thanks, Amanda and Phil. We really appreciate that.

30 DR JACKSON: You go. Yes.

MR BUTTON: I will, start but I'm going to take a step back, Phil. Building on some of your comments, and certainly thinking about it from a macro level, and
35 knowing the – how long has the cooperative been in place?

MS PROPOSCH: It's for the last 10 years. As long as the PHNs have existed.

MR BUTTON: Okay.

40 MS PROPOSCH: Yes.

MR BUTTON: So if I think about then the creation of the PHNs and the cooperative that came then to provide capability and support across the collective
45 itself, is – am I missing something here, or do we actually already have what would be considered a national performance framework for PHNs to know what they should be working towards and what good or success looks like for them?

MR AMOS: Do you mean through the cooperative itself?

MR BUTTON: Not just through the cooperative, but is there, in the – in the – that
5 commissioning relationship and that funding transfer relationship from the
departments in the first place, Department of Health, is there a base level of
understanding of the – of performance for PHNs to know what good looks like for
them?

MR AMOS: I would say that there is – there's a gap between the national guidance
10 we receive and the performance frameworks that we report into and the level of good
information, detail, as I said about what's working where and why, at the regional
level in terms of producing outcomes through the programs in this agreement, which
is probably too large. So we do receive – you know, we receive guidance from the
Commonwealth, national service models are created, and this informs the decisions
15 and the planning, you know, the trade-offs the PHNs make about where and how to
situate services and the like, and we do have performance reporting structures, but I
think there is a gap between those in terms of creating, you know, a national system
for seeing and understanding. Having actual useable insights into all that activity.
So, yes, the reporting is certainly more activity focused than it is, say, outcome
20 focused.

MR BUTTON: Yes.

MR AMOS: And, as I said, you know, quality is certainly an area where it's a
25 challenge. So I wouldn't say that in terms of understanding and driving the quality
of service models and services at the regional level, you know, that again is quite
fragmented and individualised because, you know, the data that comes up, for
example, you know, if you have a Medicare mental health centre, the data that comes
up doesn't tell you easily how is your centre performing comparing to other centres
30 in Australia, you know? Is that centre improving? What's the rate of improvement?
You know, how does it compare to other activity in other PHN areas? So there's
things we need as commissioners and performance managers that we don't have at
the moment.

MR BUTTON: And certainly in that whole feedback, and more – I should have
35 been a little bit clearer. I'm thinking more broadly not just the Mental Health and
Suicide Prevention Agreement focus in terms of initiatives that sit under that
particular agreement, but more broadly about PHN performance and what that then
looks like. Because what – if I understand where you're going here, what we've had
40 is a bunch of things like the regional commissioning guidelines and services funding
framework and a bunch of tools that have been provided to PHNs to then use for
certain component parts, but not necessarily thinking about the broader performance
of the entire organisation to make sure the organisation itself knows what good looks
like and what success looks like, then, locally, understanding there's going to be
45 different contextual needs based upon population and what's in your needs
assessment, etcetera.

MS PROPOSCH: There is a – national performance, performance and quality indicators and frameworks that the PHNs all report and are measured against and benchmarked against, in fact, and then there – the 30 individual organisations will have each of their own strategic and operational plans of which they report against.

5 And whilst some are measures, you know, are limited that are within the performance framework that goes to the Commonwealth and the data collected, individually, as organisations, we have very strong remit in building capacity and seeing impact outcomes for the individual services that we commission. And so, you know, we want our services that we fund and commission to actually deliver the impact that is expected of our respective communities.

10

So the PHNs as individual organisations are really skillful in their contract management and ability to work with providers and even partnerships of providers who they've brought together to deliver outcomes and impact, and I guess that's the point, is how do we get these individual pieces of work visible at scale nationally beyond the datasets that we share that may not tell the story that the 30 individual PHNs are actually doing across the country.

15

MR BUTTON: Yes. And certainly a lot of that reporting, as you were saying Amanda and Phil, a lot of that reporting is focused on outputs as opposed to looking at actual outcomes, and so it then becomes difficult to explain and to talk to communities and stakeholders about the impact because the outcome-based data may not be there.

20

MS PROPOSCH: Yes. Look, at an individual level, that outcomes-based data isn't. Some of that is actually clinically focused outcome measures, which can be shared, and they are shared publicly and benchmarked publicly, but to be able to do that on a really sophisticated national level would probably require some significant support and resourcing to be able to really share and bring to life what's happening locally in each individual area. So I think everyone has a heart to do that because we're here in our community in order to really improve health outcomes. We can't do that without being able to tell the story and show evidence that what we're delivering to our communities and what the service providers, in fact, are delivering to our communities.

25

30

MR BUTTON: Yes.

35

MS PROPOSCH: So yes. So sophistication of how data is collected and shared nationally, yes.

40

MR BUTTON: Yes.

MS PROPOSCH: But the use of, like you said, research and evidence and evaluation is really important. So many of the PHNs are committed to evaluation and research processes in order to document models of care that work, and so that we really can highlight it – highlight where integrated team-based models of care are actually making a real difference in our communities across the country.

45

MR BUTTON: Yes.

DR JACKSON: Where they're doing that, is that funded currently, or are they doing that?

5

MS PROPOSCH: They're probably doing it within their own funding resource envelope, or they're doing it in partnership with providers or local partners.

MR BUTTON: Yes. And how does that then connect? You mentioned the national collection of evidence initiatives, Phil. How does that then connect with that piece of work that you guys are progressing because that as you would see from the interim report, from our perspective, what we want to be able to do is get to a point where there's evidence that's being shared; there's transparency around services that are undertaking evaluations; those evaluations are made public so at least people then understand the evidence in relation to what is working and how well it's working, and we can then, essentially, point to things to say, well, this is – we're doing this because of these reasons, and here are the outcomes we're getting. Is that then – is that the whole notion of what you're thinking about, or the work that's happening in that – I guess that whole process of putting together the national collation?

20

MR AMOS: Look, I think it's a focus point for that work to come together, for that discussion and translation of that evidence that's being generated at the local level, to come up, you know, be assessed, translated and then shared back out through a, you know, curated process, and so primary health networks, as Amanda said, do do a lot of internal evaluation, partner evaluation, but, again, you know, and that's to fulfil their local requirements about transparency and accountability. It's important work. But, again, having a focus point to bring that up, assess it, you know, and I think, you know, partnerships with research and others in that space, with people with lived living experience as well, to help curate that evidence that's coming up through primary health networks, and then feed it back into the system is what's missing.

30

MS PROPOSCH: I think it would be correct to say that the transition of, in particular, mental health data to AIHW will probably provide an engine and resource of which the PHNs and community and policy-makers will really benefit from, noting their – you know, they are well positioned to probably strengthen what the data is showing. So – and that transition is, occurring, and so there's a really strong partnership between the department and AHW and the PHNs and a real commitment to not do it in isolation without working with the PHNs, so they don't miss anything, and I think that might be a really key enabler for that.

40

MR BUTTON: If I can just - - -

DR JACKSON: I'm just conscious of the time but keep going.

MR BUTTON: Okay. Just going on that one, Amanda. So, at the moment, if we think about the overall process for PHNs in the commissioning approach, the needs

45

- assessment then informs what's required, but what's being suggested, and what we have heard, not through the hearings but certainly through consultations and discussions we've had around the place, is that the feedback loop and the timing of the feedback loop from data provided to – from those commissioned entities to
- 5 AIHW that comes back to the PHN to then inform the needs analysis to determine what commissioning looks like and are we commissioning the right things and getting – and focus on improving outcomes, at the current time, that's not working in a timely manner to inform the process properly.
- 10 MS PROPOSCH: Well, it hasn't started. That hasn't started yet.
- MR BUTTON: We don't have a process at the moment where there is a feedback loop of data that comes back to inform the annual needs analysis that's happening at a PHN level?
- 15 MS PROPOSCH: Locally we do. Locally we do. And then, nationally, you would rely on some datasets that are shared nationally. Yes.
- MR BUTTON: Okay.
- 20 MS PROPOSCH: But have they – been optimised, and in using them for insights as well as they could be, is probably a question. There's a lot of information.
- MR BUTTON: Yes.
- 25 MS PROPOSCH: There's a lot of annual cycles of evaluation and needs assessments, contract management going on across the country. What brings us all together to create a sophisticated insight into understanding, you know, monitoring evaluation, the needs of our communities. We know it at a local level, absolutely.
- 30 Can we take it up further? Sorry, Phil.
- MR AMOS: Yes. So PHNs will certainly look at the existing national datasets, look at local datasets as well. I think there is different capability across PHNs to do the sophistication of that work, and I think that's where someone like the AIHW can
- 35 assist and other partnerships in certainly bringing some of those existing datasets, combining some of the existing data and reporting, bringing it down to the regional level, which is what we need. So in a lot of cases, some of the datasets don't come down to enable the sort of regional analysis that a PHN wants to do. So if we're designing, starting, okay, does that service better in this part of our primary health
- 40 network region or another part, you know, we need quite granular data at that level. And we have access to some of that, but, yes, greater feedback loops through all of the data that's generated would be really beneficial for our commissioning and planning.
- 45 DR JACKSON: We have come to time. The psychosocial supports, so, you know, obviously huge level of unmet need, and in terms of that commissioning and the need also for co-design through that process, what are PHNs doing in that space at the

moment in terms of the sort of – the co-design of the mental health supports you are delivering on the ground? Or can you give us some examples? So this is a final question, just to give you a bit of a platform to sort of – for us to go on.

5 MR AMOS: Yes. So, look, the Commonwealth psychosocial support program, as I said, is one of those legacy programs that has come through and has been sustained post-NDIS. So all PHNs will be looking at how that's co-designed into their community based on the contract and commissioning cycles that they have. So that funding has been there for over 10 years the PHNs have, and across that cycle, we
10 will take the opportunity when contracts are coming to a close to have another look at how that might be co-designed or adapted into changes in that region. What you do see at the moment, in particular, the outcomes of the codesigns the PHNs are doing is integrating that psychosocial support, alongside the other mental health stepped care, suicide prevention and other programs. So the psychosocial funding is
15 really, really valued by primary health networks because, without it, we have other, you know, primary healthcare programs.

Our largest funding schedule is primarily clinical, you know? The psychosocial is really an essential complement to allow PHNs to commission holistic models, and
20 we know this is what people with lived and living experience are calling for. They want models that will put peer workers, other workers alongside clinical workers, so they can collaborate in teams and look across the person's needs as a whole. So I think, you know, using that existing integration the PHNs have already done at the local level is already beneficial. It's already, we think, exemplifying some of the
25 best practice models for holistic care, so clinical, psychosocial and other needs at the local level.

DR JACKSON: We are running over time, so I think – thank you very much for your time. And we're all, as you know, doing a – at the PC doing another inquiry
30 into collaborative – where we're looking at collaborative commissioning, and so I'm sure we will hopefully be speaking to you on that as well - - -

MS PROPOSCH: Thank you.

35 DR JACKSON: - - - in the not-too-distant future. Thank you very much.

MR AMOS: Thanks for your time.

MR BUTTON: Our next participant is – will be Lela McGregor from the Highway
40 Foundation. Is that right?

DR JACKSON: And Charlotte James.

MR BUTTON: And Charlotte James. Charlotte, how are you? Can you hear us okay?

5 MS MCGREGOR: Thank you so much. Do you need a – do you need a moment?

MR BUTTON: No. No.

DR JACKSON: No, we're all - - -

10 MR BUTTON: We're okay. What we can do - - -

DR JACKSON: We should probably introduce ourselves actually. So I'm Commissioner Jackson, Angela Jackson and - - -

15 MR BUTTON: And I'm Selwyn Button. We have the easy part of just doing the quick introduction.

MS MCGREGOR: Yes.

20 MR BUTTON: And just to give you the instructions that when you start, can you also state your name and title and organisation, and then happy for you to go directly into your opening statement, and then we can go from there.

25 MS MCGREGOR: Sounds great. Sounds great. So good afternoon, Commissioner Button and Commissioner Jackson. We appreciate this opportunity we've been given to offer our insights on the Mental Health and Suicide Prevention Agreement. My name is Lela McGregor. I'm the CEO and founder of Highway Foundation, and I'm joined here by Charlotte James who is our policy and research lead. So this is a

five-year journey to get to this point. Highway Foundation is an award-winning national youth organisation based in Port Melbourne, Victoria. Over the past five years, we have supported thousands of young Australians that suffer from loneliness that are aged from 14 to 28 through structured peer-led programs that cultivate
5 emotional clarity, self-awareness, and confidence. We provide a relational model of care based on interconnection. We support the draft recommendation of 4.14, expanding nonclinical community-based supports, and 4.5, expanding the peer workforce.

10 Our interconnection model is a structured, nonclinical intervention that provides young people with safe and supportive environments for reflection and emotional processing. It is a form of relational care delivered within a social prescription framework. The young people who access this support are often experiencing loneliness, the number one predictor of depression, so their symptoms of low mood,
15 anxiety, and a sense of disconnection, while these presentations can resemble the symptoms of a diagnosable mental illness, they frequently arise as part of a natural period of challenge of their life.

This cohort is commonly referred as the missing middle, or those who are
20 languishing. Research by Be Well Company and leading universities indicates that 20 per cent of Australians are actually languishing today in 2024. At this core, languishing reflects a state of disconnection or self-disconnection. It is most often experienced as loneliness, which is now recognised as that – the biggest predictor of depression and other clinical mental health conditions. This is where prevention is
25 most urgently required. By intervening early through relational care, we can strengthen young people’s sense of connection, reduce the risk of escalation into clinical illness, and ease long-term demand on the health system.

Having worked with over 3000 young people to date, we have found that young
30 people facing these challenges respond well to relational models of care. 60 per cent of our service users who have sought prior mental health care found clinical care ultimately ineffective, with many having waited for up to six months to see a psychologist. Right now, when Australians seek help for symptoms such as loneliness, low mood and disconnection, the only established pathway of care is
35 medicalised. This creates three major problems. Inaccessibility: the medical system’s overwhelmed, and timely access is increasingly limited. Mismatch of care: many individuals who would benefit most from relational and preventative support are directed into medicalised pathways where their needs are not met. Delayed clinical intervention: those who do require medical care often reach a point of crisis
40 before services are available, leading to poorer outcomes and higher system costs. Consequently, we have proposed three measures to successfully address the state of crisis that currently mental health systems finds itself in.

First, we suggest to prioritise prevention early intervention. The World Health
45 Organization and the OECD both cite loneliness as being damaging as smoking 15 cigarettes a day. If we are to meet the needs of all health seekers, we must invest early before challenges escalate into clinical illness. Evidence for social prescription

is strong. Research shows that social connection reduces suicide risk by up to 60 per cent. Peer programs consistently deliver greater belonging, higher rates of help seeking and reduced reliance on clinical services.

5 Our own experience at Highway Foundation confirms this. More than 80 per cent of our participants in our programs reported increased self-efficacy and self-determination enabling them to cease help seeking after engagement. The economic case is equally clear. A standard mental health treatment plan costs Medicare between 1000 to \$1500 per person. If just 20 per cent of languishing
10 young people were supported outside the clinical system, this could deliver savings of \$200 to \$300 million annually, while freeing clinicians to focus on those with the highest need. This is a win/win. A stronger outcome for young people and a more sustainable health system.

15 We recommend a social connection pathway. We recommend a model where there's also a medicalised model and a dedicated peer-to-peer social prescription pathway. So we're looking at young people coming in, and they're seeing, "Oh, there's two ways of looking at my problem. One is a social, and one is medicalised." At the moment, if they're waiting three months to actually see a psychologist, and we know
20 it's 99.1 days, what we're asking is that while they're waiting that three months, and in that three months, if it's a small problem, it can actually escalate to something that is a clinical crisis.

While they're waiting, why not ask them to go into a relational care program, like a
25 connection program, because we know, and what we see, is that when young people really feel a sense of connection, of being seen, heard and understood, they actually find their own self-efficacy to find their way through their problem. They don't – once they go through the medicalised model, they think that it is a problem of someone else to fix their problem, whilst relational is around what is the strength in
30 me that can solve this to get myself out of this problem. And we take this problem to a medicalised environment, it takes away their own self-respect or their self-efficacy to fix their own problem.

So imagine a GP seeing a 17 year old today who is withdrawn and lonely. It seems
35 like they have a clinical problem, but, yes, it's a relational problem. Today, the GP might put them on a mental health care plan, add them into a psychologist wait list, and under our model, the GP could instead socially prescribe an interconnection program where a young person immediately joins a group of peers for structured support and conversations. And let me remind you that not all peer-to-peer is the
40 same. It's not just conversation; it's deep meaningful conversation that helps a young person really understand themselves and actually move out of the clinical and help-seeking stage. This simple redirection both relieves pressure on the medical system and ensures the young person gets timely relevant support. The best prevention possible. This is an augmented system – that is, fit for purpose.
45 Importantly, it is our opinion that the infrastructure for this revised pathway already exists, and the challenge now lies in utilising it.

- Therefore, we suggest to embed a relational and interconnectional approach into mainstream practice. Having reviewed the submissions in response to the interim report, we found a broad consensus of support for peer-to-peer work. However, a common concern among all these submissions that you received identified a lack of a
- 5 national training framework to establish a standardised peer-to-peer workforce that could deliver an effective relational model of care. Therefore, we recommend effective and safe peer-to-peer companionship is contingent on an appropriate workforce capability. This requires careful recruitment, structured training, and ongoing supervision to maintain quality, safety and consistency of care. Expanding
- 10 the peer workforce with a nationally accredited obtaining and certification program so that quality safe peer-to-peer work is available everywhere and accessible to all people. We are currently in the process of accrediting our training program with ASQA, and frequently ask - - -
- 15 MS MCGREGOR: I was putting the wider mental –Equipping the wider mental health workforce with the ability to distinguish when it’s appropriate to re-direct help-seekers to a relational model of care so they can address the social and emotional dimensions of wellbeing, not just symptoms. So we’re working side by side. We’re not saying that we don’t need clinical care. We’re saying let’s help and
- 20 really make a robust system that helps the people that need the right care. So at the moment, we have just finished a co-designed program with First Nations organisation Miriam Rose Foundation. So Miriam Rose Ungunmerr-Baumann is – was the Australian of the Year. She established the First Nations charity Miriam Rose Foundation to address suicide in First Nations young people, and we’ve created
- 25 a peer-to-peer model reflection wellbeing practice that could actually be used for First Nations communities.

So in closing, Commissioner Button and Commissioner Jackson, we ask for your consideration in recommending reforms that acknowledge a critical truth, that a social condition cannot be addressed through a purely medical model. Young Australians are facing unprecedented levels of loneliness, disconnection and inner struggle. Without early and relational intervention, many will continue to languish until they reach crisis. A parallel model of care, creating clear pathways for social connection, prioritising prevention, and embedding relational and peer-led approaches, would ease the pressure on the health system, generate cost efficiency and, most importantly, enable Australians to reconnect, belong and thrive. Thank you. And I didn't remember that. I read it out.

DR JACKSON: Thank you.

DR JACKSON: Excellent. Yes, that's good. Thank you. Look, thank you very much and thanks for your submission and all the work that you're doing in this space. In terms of, I guess, from our perspective, as we're kind of looking at the agreement itself and how the agreement can better support models of care that can be shown to be cost effective and have an evidence base, what around the infrastructure do you think would be useful to have in the next agreement, particularly around that sort of – that evidence-based approach, and we've heard from a number of participants now around the importance of research and that evidence base going forward.

MS MCGREGOR: Absolutely. We - - -

MS JAMES: Can you just summarise that question again, sorry?

DR JACKSON: Sorry. I was just asking around – sorry, you've got the feedback there. I've got the feedback myself. So look, I think you make a very – in terms of the, I guess, the evidence base and the importance of the – sorry, I'm going to send up some Dorothy Dixers that's kind of what we do to try and get some further information from you. In terms of the importance of the research and evidence and for that being embedded in the next agreement, there is that funding so that we can see what works, what is cost effective, and that that allows us to, I guess, better direct funding towards those programs, which, you know, can provide improved outcomes that are cost effective.

MS JAMES: There is work in other countries. There's lots of evidence.

MS MCGREGOR: So we're working on – so in the UK, they've also done social prescribing, which shows GP visits are down by 28 per cent, and this idea of peer-to-peer or what we call relational care is also called, what is seen in the public as spiritual care, and you have spiritual carers already working all hospitals, aged care, within schools, and it's more around a relational model. So this idea of just activating them and giving them the ability to now work mainstream, we already have the system to be able to do that. We just need to create an environment for them to be implemented, so a policy to make sure that we have good, safe, quality care from the relational model.

DR JACKSON: Now, your current funding for what you're – where is that funding coming from? Is that coming from your local PHN, from State government, from philanthropic?

- 5 MS MCGREGOR: Yes. So our current funding is purely philanthropic because most of the time, when we actually try to get funding for relational care, people say, “No, we want to fund mental health”. So we're sitting here today in front of you to say we know what young people need, but we can't get funding for relational care because it's not considered important. So the reason why that is, is because mental
- 10 health people think that when you see the symptoms that look like mental health, that young people think that they're having a mental illness, but it's not a mental illness. It has the same symptoms. It's actually just an inner struggle that they're going through as they're growing up as part of adolescence.
- 15 So it's not a recognised pathway because the only pathway a young person can see now, because there's a very strong environment around if you're unwell and you're not feeling well, it's a mental illness. And we've been very successful as – in being able to promote mental understanding and mental health that young people and parents, and my experience of working with parents is that when their young child is
- 20 going through the symptoms of a mental illness, they jump to the thought that, “Oh, my teenager has got a mental illness.” And so I think being able to regulate and

understand that there are other ways of actually taking care of their child, that there could be a relational care model, action would alleviate the mental health system which you address their real needs which is to be seen, heard and understood, which we don't have at the moment. There isn't a regular – there isn't a pathway for them.

5

MR BUTTON: With the work that you're currently doing, and you say you've had a reach into some of the programs across-the board, around 3 000 people, have you written any of that up? Have you done your own internal evaluation? Have you described your story? Because what I'm – I guess where we're getting to, Lela, is that if there is some evidence that we can point to that suggests, okay, well, here are some things that are being presented to us, which show that there's good evidence around supporting young people through the process, and is not just about the clinical component, then here are the things that we would suggest we need to consider in the future as well, that would certainly help our case in respect of the final report.

10

15

MS MCGREGOR: Yes. We definitely have a lot of research around peer-to-peer. We know that peer-to-peer actually works.

20 MR BUTTON: Yes.

MS MCGREGOR: When you're – when you – when you talk about that specific model of peer-to-peer companionship - - -

25 MR BUTTON: Yes.

MS MCGREGOR: - - - no one has ever actually written that up as a peer-to-peer for youth to use using that particular model.

30 MR BUTTON: Okay.

MS MCGREGOR: So – but I have done research on it, and it is in train of being cited and being put into a journal.

35 MR BUTTON: Okay.

MS MCGREGOR: So that was a human research – research study that is – that will actually be documented. That is why what we've done is we need funding. What we want funding is not to actually put it to our organisation. Because we see that it's quite a – we see the strong evidence of this working, we've actually gone to Parliament and asked for help to give us funding to do a human research project to be able to prove that this process, this social prescription model works. So we went to Josh Burns MP, who is in our electorate, and he has actually sponsored our petition to government to create a \$250,000 research to actually prove that it works.

40

45

MR BUTTON: Okay.

MS MCGREGOR: So that we can actually give you that statistic and give you that confidence that this peer-to-peer led companionship model really works. So – but having your recommendation that this should be done would also help us to be able to bring that forward to government to actually legitimise what we're doing, and
5 legitimise not only what we're doing but what a lot of organisations are already doing. We just don't have that research study here in Australia. So this is what we're asking your recommendation for.

MR BUTTON: Yes. No, no. Completely understand.

DR JACKSON: Sorry. And so what I was getting towards is we've spoken to a number of smaller organisations like yourselves where really your overall budgets are quite small, and, therefore, capacity to do the type of sort of research and evaluation is difficult, and which therefore makes the evidence base that you could
15 then scale things up and learn across the board – you know, you lose the I guess the local knowledge or the innovation that is occurring because you're just too small to be able to fund it. And so what we're looking at is whether you need some dedicated funding within the next agreement around research and evaluation so that that can be provided to organisations to then proof up, well, what does work, what doesn't, so
20 that we can then learn from each other. Because at the moment, you're getting these examples, and I think we spoke to yesterday Clubhouse in Frankston which, you know, different but similar peer led, you know, community-based, running off \$300, \$400,000 a year, is then – that for them to have the evidence base, you know, there isn't the funding currently in the arrangements.

Now, I understand you're completely out of the funding at the moment through philanthropic, but just to think about how we get that evidence base to then provide funders with the, I guess, the assurance that, you know, these models work and, therefore, people can learn from it across different settings.

MR BUTTON: Yes.

DR JACKSON: So - - -

MR BUTTON: That's certainly where we're coming from, is that we're hearing an emerging need to make sure that research and evaluation is embedded within the next agreement, and we're hearing that from you guys today that you're undertaking work. Your work – the reach of the work is over 3000 young people, but it's hard to then spend the time being a not for profit, being an organisation that relies on
40 philanthropic funds, to then do the research work and write it up so that it builds the evidence around it. So what we're – in our minds, it's okay, we need to have a focus on research and evidence as part of the process because it then speaks to what you're doing, what you're talking about.

MS MCGREGOR: Yes.

MR BUTTON: And then supports and enables those models to exist in other places.

MS MCGREGOR: So, Commissioner Button, when we first started with Highway, what happened is we had so much about research. So what happened, we had the research director at that time was Dr TC Chin from the Wellbeing Sciences from the University of Melbourne. So what we do is that we actually do a ready to engage.
5 We actually – we actually evaluate the young person before they do a Highway session, then we evaluate them after they've done a Highway session. So we recognise why are they coming into our system, and once they've done a session, what do they actually gain? We can give you all the research outcome of that, and we did a qualitative study which I can show you, which is 30 pages, which tells you
10 what the outcomes and what are the five key reasons why they come.

MR BUTTON: Right.

MS MCGREGOR: The three key reasons why young people actually come and – is
15 that they don't know where life is. They feel very disconnected to their future. Second, they're not confident about their future. Number 3, they feel that they are lonely, and they don't have friends. Those three key reasons, stress and mental health is so low down that system of our research that it doesn't even – it doesn't even acknowledge. So those three things are what are the causes of the young person
20 coming in and thinking that there's something wrong with them, and those three things are the things that they're taking to a psychologist and into a medical system. You can change the medical system by just taking those young people and putting them into relational care and you will – and we're projecting that 20 per cent of young people that are sitting in the system now and clogging – not clogging, but
25 making that system difficult to work will – can actually be alleviated, and they will get the care that they need.

MR BUTTON: Interested in – thank you. Interested in prevention, early
intervention focus that you have through the relational model as well. I wanted you
30 to talk a little built more about that. You did describe something, and I may be missing the point here, because you what you did describe earlier was a focus on how do we ensure that people are getting – young people are getting access to peer support during that waiting period when they're waiting to see a psychologist or to get specialist help because it's around a 90 – I think you said it's around a 90-day
35 waiting period.

MS MCGREGOR: Yes, 99.1.

MR BUTTON: 99.1. So what does that – what – is that the point of prevention and
40 early intervention? Is it at that point, or is it prior to that point you are describing in the prioritisation process?

MS MCGREGOR: We believe that the best way to do it is as soon as the young
person feels an inner struggle, or there's a struggle in life, for whatever reason, they
45 can go straight into that process of relational care because when you get to a peer-to-peer, the way that I train my facilitators is that they're also recognising, because they're Mental Health First Aid credited, they're recognising whether they

actually have a mental crisis. So they're also pushing them into – back into medical – medicalised care.

5 What we find is if it's not a medicalised care, it's a relational care issue, they can actually be solved there and then through what we call connection groups or one-on-one companionship. So not all peer led is the same. So peer-to-peer today, the academic definition of that is someone has to have had the lived experience to sit with someone else. That's what peer-to-peer is recognised. We're saying that you can be human, you can hold a space for someone else. We allow not only a person to
10 be heard, but it's the way of the young person hearing themselves, that they actually find that transformation. So it's not conversation; it's transformation. Conversation is great. You feel like you're sitting with someone, but, you know, you go with your friends, you have a conversation, you're telling them all the problems, you still walk away feeling like, "Oh, I feel empty". So it has to be trained. It's a certain type of
15 person that can do it. Not everyone can do it. So that's why you need a standardised way of care to be able to train these people so that they get quality care.

So we're saying that this evidence – we want to prove that it works because we know it works. We have five years of evidence for our stuff, which is anecdotal, but I
20 think it's really required to have evidence so that there's proof and there's confidence in being able to change the medical system in a way that will really benefit Australians.

25 MR BUTTON: Yes.

MS JAMES: Can I just add on to that?

MS MCGREGOR: Yes, please.

30 MS JAMES: I think just to answer your question a little bit more directly in terms of at what point are we hoping to jump into the kind of prevention space. The aim overall, I would say is to obviously try and prevent people needing to get to that point of crisis care, and that can happen through a kind of three, four-tiered approach. You're going to have schools' wellbeing teams who would be trained in relational
35 care, so when they notice that somebody is not doing well, they intervene, and then you would have sports organisations, youth organisations, who would have someone trained in that.

40 But then in that clinical system, that point of access would be the GP themselves. So we know that a lot of GPs, you know, mental health awareness campaigns do work. Young people are – do seek help more so than before, and they will go to GPs. Those who aren't comfortable going to GPs, it would be on that – in that space of time between going to the GP and seeing or having that first stage of the mental health plan implemented, that first visit with the psychologist, that is where we
45 would suggest sending or re-directing young people into our relational model of care. This kind of serves two purposes. We think that around 20 per cent – and this is what we hope our research study would prove – would be able to be off-boarded

during having sessions in between – whilst they’re awaiting a mental health plan and would not actually need the mental health plan in the long term, and then those who we think would need the mental health plan, because we recognise and we acknowledge that there’s a very important role played by clinical care, and some
5 young people need that more invasive clinical approach, those young people, they just wouldn’t be alone in that time that they are waiting because the wait time is too long, and they would also be more aware of themselves, more able to articulate what they’re going through, so that they can get the most help possible when that help is given to them.

10 MR BUTTON: Okay. And so one last question because I know we’re on time. So the last question for me is, because you mentioned, earlier you mentioned about Mental Health First Aid training. So in addition to Mental Health First Aid training, they would be doing also then training around understanding the relational model
15 that then supports the peer workers to then interact with young people.

MS MCGREGOR: Correct. So we believe we’re the leading organisation on training for interconnection. That ability to be able to hold a space with someone else in a way that it’s not coaching, it’s not counselling, it’s being able to just journey
20 with them, be able to understand what they’re going through. So they actually have child safety, inclusion and diversity training, and they have placement. So it’s very much around suicide risk identification and the ongoing provision to ensure quality care and mentoring. So it’s a proper certification.

25 MR BUTTON: Yes.

MS MCGREGOR: And it’s – I think it matches the need. It becomes a fit for purpose system and you’re actually addressing what a young person or a person that is going through a relational care [indistinct] in the way that’s effective.

30 MR BUTTON: Yes.

DR JACKSON: Look. Thank you, and I think it’s an interesting thing for us to be thinking about as well in terms of the peer workforce. Your point about the lived
35 experience and what the nature of that may or may not be in this space, yes, it’s something that people note down as well just for our future deliberation, so thank you for that. Look, thanks so much. Thanks for everything that you’re doing. Yes.

MS MCGREGOR: Please help us.

40 DR JACKSON: Look, it’s - - -

MR BUTTON: At least the work you’re doing is now on public record.

45 MS MCGREGOR: Thank you.

MR BUTTON: Which is a good place to start, and it's considering as part of the overall process for us in the sense of where we go with our final report and the types of things that we suggest back to government that need to change in the system to see better outcomes in the mental health space, so - - -

5

MS MCGREGOR: Yes.

DR JACKSON: And certainly, if you can share any of that evaluation, well, we can certainly have a look at it, and, like I said, the nature of this review is quite – we're looking at an agreement between the Commonwealth and the State governments, so it's not a – I'm not saying it's not a policy specific necessarily review, but we're really looking about the architecture, but examples like this of different programs that are perhaps are cost effective or can show effectiveness, they help to strengthen the case for how that architecture should work and the types of programs that should be enabled under it, if that makes sense.

15

MS MCGREGOR: Absolutely. Thank you.

MR BUTTON: Thanks very much. Really appreciate your time. Now, our next - - -

20

DR JACKSON: Apologies that we're running a little bit behind schedule. Sorry.

MS HODGES: That's okay. Hello.

25

MR BUTTON: How are you Ellie?

MS HODGES: I'm well thank you. Hope your day's going okay.

MR BUTTON: Yes, day's been good. Now, we do have some – we will get you started. What I will ask you to do before you kick off is to state your name, your position, organisation that you're from, and then you can kick off with your opening statement, and then we can go from there.

30

MS HODGES: Perfect. Thank you. My name's Ellie Hodges. I'm the CEO and founder of LELAN, the Lived Experience Leadership and Advocacy Network. We do systems advocacy targeting the mental health and social sectors in South Australia, but because of our founding and the timing that we came to be and our funding constraints, but also our organisational approach, we do thought leadership and innovation that is borderless. That means that we have quite a unique role in that we do systems advocacy from ground up of people in community with lived experience in South Australia, but our expertise around lived experience leadership and governance has had us have very deep relations with organisations in Victoria and Queensland, in particular, government and non-governments, and really helping them do organisational change and transformation across service delivery, governance and commissioning also with the Mental Health Commission in Queensland.

40

45

So we have – we also get contracted in South Australia to facilitate co-design with the sector. An example of that was several years ago they were looking at recontracting NGO mental health money, and so we led co-design with 50 per cent providers and policy project people and 50 per cent people with lived experience,
5 asking the question what is the future of mental health NGO services and what do they need to look like? So we bring rich, deep knowledge from that experience, and that's what our submission is really drawing on – that localised systemic advocacy, collective lived expertise, and looking at what it means for organisations and systems with policy input as well. And kicking in, I don't have, like, a speech, so I will just
10 say some key points.

MR BUTTON: That's okay.

DR JACKSON: No, no, no.
15

MS HODGES: And then we will get to questions.

MR BUTTON: It is much easier - - -

20 MS HODGES: So there were three things - - -

MR BUTTON: It's much easier if it's a conversation, so away you go.

MS HODGES: So the three areas that we said we could speak to would be to bring
25 a truly systemic lens to the transformation and beyond biomedical and clinical dominance, looking at the integration of lived experience, peer perspective and the workforces, and then the relevance of lived experience governance, which is beyond those, as well. So to start with we – when we looked at the report, I was actually – I really like Productivity Commission reports. I feel that they make a lot of sense, and
30 they provide a leverage for us as people with lived experience and as a peak, working at that policy systemic, trying to have real influence for change beyond service delivery.

We did feel that this one, that the Victorian Royal Commission was a very milestone
35 moment for people with lived experience and consumers that we feel wasn't drawn on as heavily as it could have been around the recommendations for lived experience leadership and trying to really push into doing different without replicating just more of the same. So – and it feels that in our state in South Australia, but also federally, there's pockets of vision, but not a set vision that's holistic and encompassing, and
40 someone leading that over generations or even beyond five years. It seems it's very linked into political cycles and short-term funding around that as well.

And we feel that we are very informed by the Water of Systems Change model, and we know that for transformational change, we need to move beyond policy and
45 practice or resource flows. We need to change the power dynamics, and we need to change the mental models that we come at this with. And I guess that's our looking to expand beyond clinical and biomedical – they have their place, but it feels like

every part of this system is designed with them in mind still, or from that world view, and that keeps us replicating what we currently have in place. And for lived experience, it's actually really interesting that the Water of Systems Change people themselves over the past 18 months, two years, have changed the mental models and the requirement to change then to actually talk and reframe it about embodied understanding, because what we see within policy, and even tender processes now, they talk about the inclusion of lived experience and peer workforce, and people more and more are talking about and using those words, but there's – we feel there's a lost in translation to the implementation of that, and actually truly embedding it in a really authentic way because we're seeing, it's great that we live in a world where practitioners and clinicians feel able to say, "Well, I have lived experience as well", and we sort of tick a box and say lived experience is covered, but it doesn't mean that is influencing their practice, their decision-making, their relationship, how they are framing the people they're supporting or who are using services or at the centre of policy.

So there's a whole nuance and complexity around that embodied knowing of what the system needs to be better and to do better that lived experience has, and our presence is so critical because we can't forget it. It's not something we've learnt and the new jargon that we're taking on or the latest research or report we've read; it's our life that we hold intimately in every moment. And so there's a – there's a different knowing and being and drilling into that that lived experience has, and that's why we are so critical for any transformation that is coming.

So a couple of things within what I've said so far is just about the clinical governance. It dominates – it trumps everything, it seems. And an example of that which keeps our system where it is – even peer models, and services that is they say they want to be peer led – through funding arrangements, we still have to sign off a header agreement that puts ve a clinical governance framework over it. So we're offering a peer program that is not clinical, but it's still governed and evaluated from a clinical viewpoint, so there's actually this tension and complete conflict around the possibility of entering into doing different around this, and we hear from people who use services all of the time, that they want connection and relational models and nonclinical in the community close to home where recovery and life happens, but the whole policy architecture is at odds with it, and we're trying to now build in a peer workforce to work different within that environment, which feels hostile at times, or where they get blamed if it's not working, or it feels like it's on our shoulders to fix it when we can be the most – that those with the least power, least resourcing and the lowest paid, and not even given full-time jobs a lot of the time.

And I have an example that LELAN has led in South Australia to get out of that, but it was a lot – it was a long arduous journey to get there. There's a model Alternatives to Suicide, which is peer led, community-based, 90-minute groups – it comes out of the US – where they are held fortnightly or weekly or other derivations of that, and current approach is very simplistically someone turns up somewhere and says, "Living is hard, and I want to die", that instantly a risk assessment starts. They

will be told to go to ED or GP, police and/or ambulance may be called. If they were to leave, a welfare check would happen, and that may all be without their consent or it may be, depending, but we know generally how it goes.

5 Alt2Su groups, we train peers who have their own lived experience of suicidality to hold these groups. There is no risk assessment ever. There's no direction to ED, GP, no police, no ambulance, no matter what is said, if they come and say, "Living is hard; I want to die". If they leave, there is no welfare check afterwards. If they say their name is Fred, then we call them Fred. When we first tried to seek funding for
10 this model in South Australia and to embed it holistically and to prove that peer led can be done, because we could have sat there as an advocacy organisation for 10 years and nothing could have happened. We found an opportunity to bring it ourselves. If we worked with – we had funding in the beginning from both PHNs in South Australia and State government, but it took 18 months from – and saying they
15 would fund us to signing contracts to get an exemption from a clinical governance framework in our header agreement because we held ground that they were at odds with each other, and they worked with us.

We now are at the point where each year our funding has reduced. We no longer
20 have funding from PHNs and our state only because it's such a novel, different, innovative way, and there's a lot of fear because we are so risk averse about it. So we try and do these innovative new models, but all of the back end doesn't enable us to do that. Another example is – yes.

25 DR JACKSON: I want to ask you whether there was an evaluation of that had been done? I'm sorry, I know that's a clinical theme, but we're just looking for sort of the evidence base by which we can demonstrate maybe how the current system isn't funding evidence-based approaches.

30 MS HODGES: We did have an evaluation about it. Because the model, we don't get all of the demographics data, it's anonymous and confidential for people to come, but we did have an evaluation alongside that I can submit to you - - -

DR JACKSON: Yes. That would be great.

35 MS HODGES: - - - to look at that.

DR JACKSON: Thank you. Thank you very much.

40 MS HODGES: Another example LELAN has is several years ago we worked with Mind Australia. They piloted a hospital-avoidance program in Adelaide's north that was peer led but in a mainstream organisation. An evaluation developmental along the way worked with them to land at the end of a nine-month pilot period on a model for peer-led service delivery that was shown to be effective by measures that they
45 had, but then getting ongoing funding hasn't happened around it. So that's something of the challenges there.

We also have examples where when people work with us, and it's really relational and builds over time, that LELAN has been able to do some of this work, and people in other places across the system, that commissioning we've proven that if lived experience is strong and sticks with it, it can be done differently. Through this set-up
5 of a safe haven in Adelaide's north, it came from a group of organisations that come together as an alliance, looking at need and going, "We need a safe haven." The State, the LHN, community members and services then worked together really closely to get that service set up through the modelling of it and co-design, and then the commissioning, lived experience had a greater voice of influence.

10 The PHN adapted and had LELAN involved to set up – normally there's a panel for commissioning, and they may have a single person with lived experience on it. We set up a whole separate panel of people with lived experience to come up with scenarios and questions that preferred providers were asked in the tender process and
15 had to respond to, and a person from that panel sat on the main panel. We've replicated that differently for a recent piece of work in a family domestic sexual violence work with both Adelaide PHN and Country SA PHN where rather than a panel like that, because timing and resourcing was different, but where people with lived experience – a panel that we hold created three questions and a criteria for
20 judging them that preferred providers were judged on, and that – the decision of our lived experience panel influenced the final decision. So when it's worked at with good people sticking in and holding ground, it can be done differently. We just don't see that it – it's normally given the time or the resourcing to do that. Something else – sorry, I'm just looking at my notes around this. The role of lived experience peak –
25 sorry, did you want to chat with each other?.

DR JACKSON: Sorry, I was just noting it's very similar to what – the model that worked very well in the Cape York, what you're just described, in terms of how they go around the commissioning of services, that sort of panel-type approach and the –
30 sorry, it was just drawing a link [indistinct] you keep going. Okay. Sorry.

MS HODGES: Thank you. I guess what these examples show is that lived experience peak bodies are really important. The Productivity Commission report really highlighted the role of the national peak, the new Consumer Alliance which
35 LELAN is part of the board and that federated model. But the importance of that is extremely relevant at State and Territory jurisdictional level because there needs to be a parallel process of what's happening federally as what's happening on the ground or more localised in the State because we have the relationships where the rubber hits the ground, I guess, or where services exist.

40 And at the moment, across our jurisdictions, there's huge inequity in the investment and resourcing of the peaks, and I say this from LELAN who has, what, we only get 200,000 per year to be a peak and be involved in all of this stuff. Fortunately, at the moment, LELAN is in a position, because we do fee for service work, we self-fund a
45 lot of our systems advocacy and the work that we do, but in the future, if the bilateral agreements are fully realised, and the States and federal system is working closer together, the role of lived experience needs to be equally in there to bring system

accountability back to community and the people that use services, so we need to be adequately resourced at those same levels.

5 For an example, just yesterday, invitations came for LELAN to be part of joint regional planning for Country SA PHN. There are three workshops. At the moment, you could say we are funded to go and attend those, but that's in amongst all of the other asks, and our funding packet is only \$200,000 per year for that, which when you look at operational costs and FTE, it's essentially one point not much to be able to do that. So just raise that inequity across the country around that. We have – WA, 10 they get – well, last financial year, \$1.86 million and variance across it, and the federal one is a bit more, but in the budget, when they were announced, it was about \$800,000 each. So just looking at equity and how we have true input that brings an integrity process to it.

15 MR BUTTON: Yes. And just - - -

MS HODGES: Some - - -

20 MR BUTTON: You keep going, Ellie. You get your – if you keep going and get the points out that you want to make, then we can make sure that at least we've got some time for questioning, but I want to make sure you get your stuff on the public record first.

25 MS HODGES: Thank you. Something else that's important throughout the report and the request for information was about the integration of lived experience peer workforces. We believe that that is really critically important, and we see that happening to various degrees. I think there's a lot of immaturity in the system in that approach. We have Medicare Mental Health Centres that are doing it, locals in Victoria, and LELAN, I guess, we do have a different insight because we walk 30 beside organisations as they implement those. What we still see within those environments, clinical governance framings and leadership isn't at the same level as the peer leadership. So if there's a difference in approach or a difference of opinion or practice, clinical wins out at the moment. And it has its place to have multidisciplinary integrated teams, but we need to create space for peer led and peer 35 governed and peer owned as well, for some of the reasons that I've already mentioned. So it's not just solely integration, and this isn't about those spaces and lived experience being anti-clinical, anti-psychiatry, anti-current system. We need to offer more choice and more control and let people choose for themselves and have the dignity and autonomy to find the place that best meets their needs and approaches 40 as well.

And there's a whole lot of work we've done in that space that we can share or not with it. I'm conscious of time, so the other thing that I will just say before opening up is there is an alternative to lived – to clinical governance. We were really 45 fortunate a couple of years ago to be commissioned to develop a lived experience governance framework, and sometimes I get into a quandary about whether we named it correctly because people then think it's about the lived experience

workforce or representatives and advocates having more places at tables or in roles. It's not that at all. Lived experience governance is the greater paradigm and approach that shifts the way risk is looked at and safety is promoted for people, and decision-making put in the hands of who is using services. So the lived experience governance framework is putting the people at the heart of policy and service design and use at the centre, and then everyone else within the system, keeping them in mind in the design, implementation, delivery and also evaluation and continuous improvement of it.

10 When we developed this, we spoke to over 200 people across Australia: lived experience leaders, policy leaders, statutory – people in statutory roles, and people leading mental health public services and systems within it, so it was quite robust, and we asked them the question do we just need to evolve clinical governance or put up lived experience governance as an alternative? Unanimously, they said we need to evolve where we are. We are not there. It will be a long time. So you need to put up lived experience governance to help the evolution there. So there's a whole framework that has been created around lived experience governance. Mind Australia we worked with for the past 18 months to actually translate it for peer-led environments and services to – and because the Royal Commission, the healing place there, which is a peer-led acute residential, that the development has been funded and waiting to see if implementation will occur, but we are also now working with Mind Australia to look at the integration of lived experience governance with clinical governance in the locals that are happening in Victoria because they hold three of them and two satellite ones.

25 So there are things out there. It's just how we get them on the radar and the capacity to test them and then have them resourced thereafter. Lived experience is talked about all of the time, but it's the first thing that drops off radars when things get busy within services and organisations. I will stop there. I could keep talking for about five days so - - -

30 DR JACKSON: No, no. It's been, like, thank you. It's really, really useful, and we would love anything that you can share with us with would – I know the team is going to look at me and go no, no. But I think, yes, we really, really value that, so please, that work would be really, really valued. I just want to ask a quick question, and then I will throw to Selwyn. You talk about transforming views, transforming perspectives within the system, and that sort of real cultural piece, I think, is what you're getting at. What importance would the – I guess both the relief and implementation of a stigma and discrimination strategy in this space have with your – in your mind about sort of driving some of that cultural change and awareness?

40 MS HODGES: So I have two answers to that. One of them is that was a really big piece of work that was done that was really momentous, and, from a lived experience perspective, we would say there has been investment in that why wouldn't it be released publicly to drive things? Someone thought at some point it was meaningful to do.

DR JACKSON: Yes.

MS HODGES: When it comes to will that change things, I don't know that we're talking – that as that – as the main part of what needs to drive transformation, it's
5 important and to have it on – you know, Selwyn, you were saying before to the people before me, “You're now on public record”, and you said to put me on public record. It's – sometimes in our advocacy at LELAN, we know, and part of this process is it may not change anything now, but by having it on public record, others can leverage it for the next conversations that happen. And to have it named as
10 discrimination is important because a lot of people still call it stigma, but it's structurally embedded in justice, oppression, misattribution of what people's experience are of distress, that is important to have out there.

MR BUTTON: Interested to get an understanding in terms of the jurisdictional stuff
15 you talked about earlier, and knowing that you've had some – had some wins, some losses, but certainly getting an understanding of what it would look like in an ideal sense from a South Australian perspective in that jurisdiction, lived experience involved in design, governance and any oversight of the bilateral, because, obviously, there will be a national agreement. Each national agreement or they have
20 a bilateral for each jurisdiction. What does good involvement of lived experience look like in the bilateral design and implementation process for you?

MS HODGES: So any structures that exist around governance need to have lived experience there. And we always say that LELANs presence, we bring collective
25 representation and highly systemic and strategic input, which is different from individuals with lived experience, who need a voice and input as well. And so then any governance structure needs to have representation and inclusion in the decision-making and evolve out of the bilateral agreements. What it also looks at, and in South Australia we actually do have an example of how it has happened,
30 which is unique, and it shows how it can happen in pockets where there's relationship. Part of our bilateral agreement has been a set-up of the mental health, Medicare Mental – the Medicare Mental Health Centre and the Crisis Stabilisation Centre in Adelaide's north. Since the end of 2022, a project team of State, PHN, local health network and LELAN have met to look at the design and rollout of that.

35 So we were viewed at the start as really critically important. We have led some co-design throughout that process. We have shown up to a lot of meetings to hold fidelity to lived experience. When there have been very high-level big governance meetings, we were part of that conversation and even talking about ligature points. If
40 we're trying to do different, then why would we keep thinking, and LELAN has played – and I'm not overstating this, because there's huge bias, but it's what others have said as well – is that we keep people on track around it. For the first 18 months, that group met weekly. We called ourselves the Tuesday crew. Then a couple of people went to a different position, and then we picked up, and we now meet
45 fortnightly about that. The crisis – so Medicare Mental Health Centre came online last April, Crisis Stabilisation Centre is due to come online in March next year.

Even – there's a philosophy of care that underpins these that LELAN and TACSI and other organisation co-designed with people with lived experience saying this is a service experience we expect and want, and that has been a foundation of this work, and LELAN, because it matters to us, we keep homing in, and this is a power of peak
5 body that stays around. Here we are, three years later, still talking about and still asking questions so that that intent is held. So there are examples where lived experience can be part of a bilateral rollout. It just so far has depended on relationship, and we need it structurally embedded, and, as I said, there are workshops happening in September for Country PHN about joint regional planning.
10 We will be there. Sometimes we need it stated and written, not taken as an implicit thing, because we know what's implicit isn't explicit for everyone at the same time. And then we need to be resourced to be able to do that.

MR BUTTON: Yes.
15

DR JACKSON: Do you see your role also for the state peaks – sorry, I'm just – can I have a thought bubble? Am I allowed a thought bubble, please?

DR JACKSON: If we think about scope of practice for peer workers, if we're
20 thinking about training, if we think about all those types of accreditation, is there a role there, do you think, for, or a need there for that workforce development – that oversight as well that's funded.

MS HODGES: Absolutely, yes.
25 Absolutely.

DR JACKSON: Yes.

MS HODGES: What is being built into policy documents and commissioning is
30 everyone's talking about we need lived experience, we need peer workforce, but there hasn't actually been a lens given to the capability, capacity building and building a pipeline of development of that workforce, but then we're meant to come in and be good to go. And one of the critiques I have in South Australia, and that our department knows very strongly because they hear from us, is that leadership roles,
35 when they come up, who is there to authentically bring that lived experience? People who know the value base, the practice base, the technical skill set in its own right and connected to the movement, because it is a social movement, rather than getting people who have been in high-level jobs and then just disclose lived experience, but they don't actually bring a lived experience world view or perspective or values to
40 their practice. And we will see that increasingly, and we do in Victoria and Queensland where there is more money.

DR JACKSON: Okay.

MR BUTTON: Yes.

5 MS HODGES: We need an incubator.

DR JACKSON: Yes.

10 MR BUTTON: And certainly building on that, not to – I know we're out of time, and this has been a great conversation, Ellie, but then having undertaken the work that we're sort of suggesting, and I know that there's – it's happening in pockets around developing a scope of practice and understanding, will go towards supporting the professionalisation of those sorts of things, so then at least systems get a better understanding of how to embed lived experience workers in the workforce and – and
15 those in the network within the work that they're doing as well?

MS HODGES: Absolutely. And the – last year's budget, the \$7.1 million for the National Peer Workforce Association has been made. It's being talked about it will go to tender. Well, it was meant to have gone before. It's coming eventually, they
20 say. It's just those things, how we – and is that the only mechanism required? I don't know. But we need something.

MR BUTTON: Yes. It's a starting point to then build upon.

25 MS HODGES: Yes.

DR JACKSON: Look, thank you so much for your time, for your work, everything. So it has really been fantastic, and I'm sure we will probably be in contact again, and, yes, welcome the additional information. Whatever you could provide would be
30 fantastic.

MS HODGES: Thank you. Apologies to your team. We will send it through, and very open to having a separate conversation with anyone in the team if helpful. Thank you.

35 DR JACKSON: Great. Thank you.

MR BUTTON: That would be great.

40 DR JACKSON: Enjoy rest of your day.

MR BUTTON: Thanks very much.

45 MS HODGES: You too. Bye.

DR JACKSON: I think we've just got a very short break before our next participant. So we will be back very shortly.

ADJOURNED

[3.03 pm]

RESUMED

[3.07 pm]

5

MR BUTTON: Welcome back. We will now commence – recommence with our last session for the afternoon, and I do believe that we have our last participant for the day that’s in the Melbourne office. Melissa, I think we have you online.

10 Hopefully, we’re - - -

DR JACKSON: Okay. Here we go. Good afternoon. Waiting for the cameras to work.

15

MR BUTTON: Lizzy, can you hear us okay?

MS PAGE: There I am.

20 MR BUTTON: There you are. Excellent.

DR JACKSON: Good afternoon. We’re back online. How are you?

25 MS PAGE: Excellent.

MR BUTTON: - - - just to clarify, you prefer Lizzy?

MS PAGE: Yes. Yes.

30

DR JACKSON: So I’m Commissioner Jackson and this is Commissioner - - -

MR BUTTON: I’m Selwyn.

35 DR JACKSON: - - - Button. We’re up in Canberra today so – but fantastic you could join us from the Melbourne office, and thank you very much for coming in and providing us with your evidence. Are you comfortable starting with an opening statement before we move to questions?

40 MS PAGE: Yes, I have quite a bit of an opening statement. I apologise.

DR JACKSON: No. No. That’s - - -

MS PAGE: Yes.

MR BUTTON: I can see you've got some nice big notes in front of you there, Lizzy, so we're going to hand over to you, so that you can read your statement and go through the process. Take your time. But what we want you to do before you kick off is to make sure that you start by providing your name, and then we can get into the – so at least for the transcript, we know who is making the representations today, and then you can get into your opening statement. So if you do that for us, thank you very much.

MS PAGE: My name is Melissa Lizzy Page, and I am here today representing myself as a person with lived experience of mental health issues and suicidal ideation. I've worked as a mental health advocate for a number of years and have also had experiences of mistreatment within the mental health system.

MR BUTTON: Thank you.

DR JACKSON: Thank you.

MR BUTTON: Away you go.

MS PAGE: Lovely. I would like to start with an acknowledgement of Country and just say I would like to acknowledge the traditional custodians of the lands on which I live, work and write, and I pay my respects to the Elders, past and present. I affirm that First Nations sovereignty was never ceded. This always was and always will be Aboriginal land.

Justice demands more than words. In 2008, Prime Minister Kevin Rudd resolved to close the gap in life expectancy, education and economic opportunity, but those resolutions cannot be realised without truth telling and a treaty, one that recognises First Nations sovereignty, guarantee self-determination and secures the right to live free from systemic violence and dispossession. As someone with lived experience of mental distress and suicidal ideation, I speak for my own intersectional position – not for others but alongside them, adding my voice to the growing call for justice and ethical reform. I honour those whose experiences remain unheard, especially those whose suffering was so great they are no longer here. May they be remembered, believed and never forgotten. The struggle for justice in this country, for First Nations people, for those harmed by the mental health system, for all who have been silenced is one struggle. My own lived experience is part of it, shaped by systems that too often mistake containment for care, and survival for success. So I ask, what kind of country do we wish to be?

Now, that may sound too big a statement for a public hearing, but it isn't, because the way we treat those struggling the most is the measure of who we are. The work of this Commission will shape millions of lives and direct billions of dollars. It will decide whether we follow the United States and the UK towards rising crime, poverty and suffering, or whether we have the courage and the intelligence to strive

for something better. Health reform cannot be measured by statistics and expenditure alone. It must be grounded in what the philosopher Hegel called *sittlichkeit*, the unity of individual freedom and collective responsibilities made real through just and humane institutions, and by institutions, I mean not just hospitals,
5 but also child care centres, police stations, universities, aged care facilities, and even our own Parliament.

Mental health is not an isolated service for moments of crisis. It is part of the ethical fabric that hold our families, communities and government together. If that fabric is
10 frayed, it cannot be mended with Band-Aid services or short-term fixes. It must be rewoven into the everyday life of this country, so that dignity and care are sustained, not by emergency intervention or reactionary responses, but by the ordinary functioning of our institutions. The highest ethical task of government is to realise freedom, not simply as the absence of restraint, but as the capacity for
15 self-determination, grounded in reason and mutual recognition. But here's the challenge: freedom cannot exist when people with mental health challenges are treated as others, as objects or burdens requiring management, rather than people capable of reason, dignity and contribution. I ask the commissioners to recognise the ethical shift required is not only in the system, but also in yourselves, to see us not as
20 problems to be corrected with rules and restraint, but as people whose suffering has meaning, whose voices carry truth, and whose participation is essential to the very idea of freedom.

This is not abstract philosophy. It is the ground from which urgent concrete reforms
25 must grow, and that begins with the labels that we use. The first step is to end the use of personality disorder diagnoses. These are not neutral medical facts; they are the modern inheritors of hysteria, once used to pathologise and discredit emotional suffering. Another meaning of hysterical is a very funny joke, and too often our experiences of mental distress have been treated the same way, as something to be
30 laughed off. Personality disorder labels do not reveal the truth of suffering. They pathologise the effects of violence, abuse and structural injustice. They act as moral judgments, disguised as medicine, branding ordinary people with permanent marks of supposed defectiveness. Instead, we need-trauma-informed narrative-based approaches that recognise pain as rational human responses to harm, not a flaw in the
35 individual. By discontinuing the use of such terms, mental health services can reconcile universal standards of care with the lived realities of those experiencing emotional distress. But changing labels alone is not enough. The ways in which we deliver care also matter.

40 Second, we need to end the behavioural monopoly and transform education. If CBT and DBT were the answer, suicide rates would be falling, but they are not. The government must break the behavioural monopoly that reduces mental health care to scripted centre management. A truly ethical system is pluralistic, embracing long-term psychodynamic therapy, liberation psychology, psychoanalysis, First
45 Nations healing and culturally anchored forms of care. By bridging these traditions, we create a richer ethical life, one that refuses to collapse the universal need for healing into a single method tied to a dehumanising set of symptoms.

Clinicians must be trained to listen, not simply to categorise or manage risks. Ethics must be at the centre of professional formation because freedom and dignity cannot be reconciled with training that treats people as problems to be solved.

5 This becomes even more urgent as artificial intelligence shapes what counts as true
knowledge. While we have mapped human consciousness in unprecedented ways,
psychology departments continue to rely on outdated models such as classical and
operant conditioning, frameworks that were discredited nearly a decade ago. If the
10 government is to be the highest ethical institution, professional training must reflect
the best contemporary knowledge, not the sediment of obsolete paradigms. Our
country must stop following and start leading. To achieve that, we must resolve to
reconcile the past.

15 The third step towards meaningful health reform is to launch a national inquiry into
psychiatric harm. Ethical life is rooted in history. Australia cannot build trust in its
institutions without confronting the legacy of coercion, neglect and abuse. From
harm inflicted on First Nations people to the institutional betrayal of children in state
care. This is not optional; it is urgent. A national inquiry into psychiatric harm must
20 be established, co-led by First Nations people and independent of the institutions
implicated in the very harms under investigation. The recent federal election made
one thing clear: rising poverty, crime and social despair are pressing public
concerns. These are not isolated problems. They are the symptoms of systemic
failure to provide minimum standards of mental health care. An inquiry would not
25 only serve as a moral act of reckoning, but it would also uncover the root causes of
harm, enabling reforms that protect our communities and prevent further injustice.
The health of our democracy depends on our willingness to confront these failures,
openly to acknowledge what was done to those harmed, accept that taxpayer money
was wasted, and transform the institutions that caused it. Anything less is
30 complicity.

The fourth and final step is to make long-term mental health support available
through Medicare. Responding to [emotional distress takes time, yet Australia's
Medicare system only funds short-term interventions. This pushes people towards
emergency departments, instead of providing the ongoing care needed to cope with
35 life's challenges and sustain mental health. In 2023/'24, 12.6 million Medicare
subsidised mental health services were provided to 2.7 million Australians, an
average of just five sessions each. This is not good policy. It is people giving up
because the system is too complex, too limited and too expensive to truly support
them in crisis. The limits don't just hurt service users. Clinicians are forced to work
40 within a system that prevents them from providing real care. The emotional and
ethical toll of watching people cycle through crisis without being able to offer
meaningful support fuels burn out and psychological injury, and, of course, clinicians
cannot access long-term therapy under Medicare either. Nobody wins, but we all
lose. We must reform Medicare to fund long-term therapy, prioritise ethics-focused
45 and trauma-informed care, and build a culturally competent workforce. This is not
charity; it is a core responsibility. Government's role is not just to manage
emergencies but to structure society so that freedom, dignity and mutual recognition
are the rule, not the exception.

These four reforms are not a wish list. They are the bare minimum, ethical commitments of a society that takes seriously its duty to reconcile individual freedom with a universal good. As Hegel reminds us the rational government is the ethical whole, individual and the collective stand in mutual recognition. That ideal is not abstract. It is measured in the lives of people who walk into clinics and hospitals every day, searching for care, and instead encountering a system that dismisses, excludes, and too often harms them. Mental health reform in Australia is not a marginal policy issue. It is a test of who we are as a nation, of whether we're willing to build a society where no one's suffering is written off, silenced or reduced to a category, but instead is met with structures of care and recognition that make freedom real. The question before us is not whether reform is possible. It is whether our leaders in Canberra are willing to confront the reality of suffering, admit the failures of our institutions, and show the courage to build something worthy of the people they are elected to serve. Thank you.

DR JACKSON: Thank you. Did you have – I've got one question for you, Lizzy, which is just around – we've had it suggested from other participants in this public – these public hearings around the need for a more human rights approach, or a human rights approach to the agreement, to underpin it. I just wanted to, I guess, test with you your views around that, and whether you think that that might provide the types of reforms or the flow-on reforms that you've been talking about today.

MS PAGE: Yes, I do agree. I think as long as that – as long as it is centred around ethics, and that it isn't just a branding exercise. So sometimes, you know, we say things like human rights and all of that sort of stuff, but we don't understand that we're talking about ethics, and that it has to be meaningful, and it has to be real. Yes. That we need to make sure that when we form any sort of document or policy or piece of legislation, that it's actually something meaningful and not just a superficial speech with – yes.

DR JACKSON: Yes. And Selwyn?

MR BUTTON: Wanted to touch on your last point, Lizzy, which is a good one, and hasn't come up in the hearing. Has come up previously in conversations when we were doing site visits and undertaking consultations around the reduction of the Medicare-funded psychologist services, and I guess I'm wanting to tease that out in the sense of what that looks like. So it's reduction that has occurred, and what you're suggesting now is we need to go back to where we were, or are you suggesting we need to look at increasing what that looks like?

MS PAGE: I think it's going to be really important to really understand how we can do that in a way that isn't wasteful because, obviously, just say you can have as many Medicare sessions as you want, like, how do we make sure that people are actually getting the support that they need, and that it's not just something that's being taken advantage of. So I think that we really need to revisit and not go back to the past, but try and develop something new where there are – we've been able to make sure that that Medicare system is functioning properly.

MR BUTTON: Okay.

MS PAGE: Yes.

5 MR BUTTON: So what you're suggesting, then, is more about a bit of a review of
the usage of that as a Medicare item to determine in what best – what's the best
needs to suit the system based upon the usage of the item, and really access as well
because you need to overlay access because that will also determine how many visits
an individual can get into.

10 MS PAGE: Absolutely. And I think we've seen that a little bit in the NDIS space
where we've got, you know, people who are allocated funding, and I think from the –
in the NDIS space, it's very expensive because, you know, we need ways to be able
to make this cost effective. Just saying we're going to pay – I think it's something
15 like \$220 or something like that for a psychology session. Can we, I don't know,
maybe set up clinics or something like that where people are able to access those
sessions and paying someone privately. Yes.

MR BUTTON: Yes. That becomes a bit of a barrier to access the services to
20 support them.

MS PAGE: Absolutely. Absolutely.

DR JACKSON: Now, we do need to wrap up proceedings today, as you're aware.
25 Did you have anything final you wanted to add to the public record? And thank you
very much. You know, your statement was, you know, expansive in terms of – but
very eloquent and clear from our perspective. So thank you very much for the time
and effort that you've obviously put into that. It's something I think, for the public
record, that will stand the test of time, and we really appreciate that today. But did
30 you have anything else you wanted to add?

MS PAGE: I just wanted to say thank you to the Commission for identifying that
there were problems with the agreement because it's something that I felt in my
heart, and, you know, when I read your interim report, I was, like, finally someone
35 has seen it, and I really – yes, it's why I put a lot of time into this because I read it.

MR BUTTON: Well, thank you for putting the time in that you have, Lizzy. It's
been great to hear your thoughts today and certainly your insights into being a
consumer of the system, but also understanding what goes into the agreement as
40 well.

MS PAGE: Yes.

MR BUTTON: We've – it's certainly given us plenty to take away today, and
45 showing your bravery to present up to our office in Melbourne to present it to us as
well. So thank you.

MS PAGE: Yes. Thank you.

MR BUTTON: Thank you very much for doing that.

5 DR JACKSON: Now, Natasha Belmont from Relationships Australia, as part of our
process in this inquiry, all individuals – people who are appearing as individuals are
contacted to be offered a sort of any – somebody to talk to after providing evidence,
and that service is actually available to everybody who has appeared as well. So she
will be in contact shortly, just so that you're aware of that. But, otherwise, thank you
10 very much, and have you got our formal closing?

MR BUTTON: And look, that concludes the scheduled public hearings. Before I
formally close the proceedings, if there was anyone else who wants to appear today
before the Commission, please use the reactions to raise your hand.
15

DR JACKSON: I think that's it, so thank you very much - - -

MR BUTTON: Thank you very much.

20 DR JACKSON: - - - to everyone that has tuned in and to everybody who has
appeared. Thank you.

MR BUTTON: Thank you.

25 **MATTER ADJOURNED at 3.27 pm INDEFINITELY**