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Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

PROF STEPHEN KING, COMMISSIONER
MS JULIE ABRAMSON, COMMISSIONER
PROF HARVEY WHITEFORD, ASSOCIATED COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

AT DIALOGUE 4 NATIONAL CIRCUIT, BARTON, CANBERRA
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PROF KING: So, good morning everyone, and welcome to the public hearings following the release of our draft report of the Productivity Commission's Inquiry into Improving Mental Health in Australia. My name is Stephen King and I'm the presiding Commissioner on this inquiry. My fellow commissioners are Julie Abramson and Harvey Whiteford.

Before we begin today's proceedings, I'd like to acknowledge the Ngunnawal people, who are the traditional custodians of the land on which we meet today, and pay my respects to Elders past and present and emerging. I extend this respect to all Aboriginal and Torres Strait Islander people attending today's meeting.

The purpose of this round of hearings is to facilitate public scrutiny of the Commission's work, and to receive comments and feedback on the draft report. It is a draft report, so we know that hopefully there are some things in there that are right, and we know that there are some things that people will disagree with, and we know that there are some things missing. And really, what we're here today is - it's nice if you tell us what we've got right, but really, what we want to know is what we've got wrong, what's missing.

We're here to really listen to you, so we're not going to be debating and say, I hate Recommendation 3. How did you come up with that? We'll be saying, well, fine. Why do you hate Recommendation 3? We're not going to try and defend or say, no, we were right, or anything like that. That's not the purpose of these. We recognise this is draft. We recognise that there is a lot of work to be done between draft and final in May, when it goes to the government.

Now, this hearing in Canberra is one of many we'll have around Australia, in all the states and territories, in both capital cities and regional areas. We'll be working towards completing the final report to government in May, having considered all the evidence presented at the hearings and submissions, as well as other informal discussions. Submissions and comments to the Inquiry will close on 23 January. Sorry about that, but the timelines are dictated to us.

Participants and those who have registered their interest in the Inquiry will automatically be advised of the final report release by government, which may be up to 25 parliamentary sitting days after completion. But it will be released. We'll conduct all hearings in a reasonably informal manner, but I would like to remind participants that there are clear structures in our legislation for how these hearings are legally backed, and a full transcript is taken.

You may notice microphones. The microphones are for the transcript. They're not for amplification. So if I could ask people presenting if they could speak up so that the dialogue isn't just between us; it involves the people in the audience, and they'll be able to hear what's happening. For this reason though, comments from the floor cannot be taken, because we don't have microphones. So comments, issues, and so on, unfortunately can't - we can't have a three-way dialogue going here.

The transcript taken today will be made available to participants, and will be available on the Commission's website following the hearings. Submissions are also available on the website. Participants are not required to take an oath, but should be truthful in their remarks. Participants are welcome to comment on issues raised in other submissions. I ask participants to ensure that their remarks are not defamatory of any other parties.

Now, we know that many people here today are going to talk from personal experience. Just please be aware of privacy protections, and if you can refrain from naming specific individuals, that would be good. We want to make sure people can tell their story, but we also don't want to have issues about privacy and defamation, because it is public.

Let me go back to where I was. You are all free to enter and exit the room as you want. If anyone needs a quite space, please feel free to exit the hearing and use the space by the tea and coffee area. I don't know if there's any media here. If there are media here, then please make sure you've identified yourself to staff, and given the nature of proceedings, please be respectful in your approach. If anyone is feeling distressed at any time, just please approach one of our staff for assistance.

MS ABRAMSON: Who are sitting at the back.

PROF KING: Sorry, at the back there.

MS ABRAMSON: And you put your hands up. Thanks, team.

PROF KING: Yes. In the unlikely event of an emergency requiring evacuation of this building, the exits are located directly on my left, your right. Upon hearing the evacuation tone, please leave the building and assemble at the grassed area on Bligh Street, unless given an alternative assembly point by the fire wardens. I think that's - - -

MS ABRAMSON: They're looking at Alistair.

PROF KING: That's down in front of the Kurrajong, because I've got no idea which one is Bligh Street.

MS ABRAMSON: He knows though.

PROF KING: Yes. Your assembly point is in front of the Kurrajong there. If you require assistance, please speak to one of our team members. I've already said that. That's in here twice. Our first participants today are going to be representatives from Mental Health Australia. I invite them to identify themselves for the purpose of the record.

MR LOVELOCK: Thank you. Harry Lovelock, Director Policy and Projects, Mental Health Australia.

MS HATFIELD: Ingrid Hatfield, Senior Policy and Projects Officer, Mental Health Australia.

PROF KING: And do you have an opening statement.

MR LOVELOCK: Thank you. I've got and opening statement prepared that I'll read for you now and provide to the Commission. Thank you for the opportunity to discuss the draft report of the Productivity Commission Inquiry into Mental Health. Mental Health Australia is the peak national, non-government organisation representing and promoting the interests of the Australian mental health sector, and committed to achieving mental health for all Australians.

Mental Health Australia has 120 members, which include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers, and state and territory community mental health peak bodies. The Productivity Commission's draft report provides a valuable, up-to-date statement on the significant economic costs of mental illness. It properly places the experience of mental illness in a broader social context.

We commend the commission for reviewing areas and social determinants of mental health, including housing, justice, education, and employment. We also commend the Commission for grappling with details of governments and accountability. The Productivity Commission rightly acknowledges in the draft report the lack of national vision for mental health. The Commission further acknowledges we do not have the governance structures necessary to support national collaboration in this area.

The experience of the sector learned over decades is that the key to change is sustained and supported implementation. We understand how little benefit comes from applying, or band-aid solutions. Though the Productivity Commission has well understood the complex barriers to reform, the recommendations as they currently stand do not offer enough to provide the breadth of change needed.

It is not enough to simply do what we do now, but better. We need systemic reform that articulates and implements a vision of cohesive mental health system, driving towards recovery and participation. Our vision for mental health in Australia is outlined in the mental health sector's Charter 2020: Time to Fix Mental Health, signed by 110 organisations. It is through the lens of the Charter and its nine principles for mental health reform that we will measure the success of this Inquiry.

There are some substantial recommendations in the Productivity Commission's draft report which goes some way to achieving these necessary systemic reforms. Foremost is a recognition of the need for a new mental health service agreement to provide clarity and accountability for the responsibilities of different levels of government in funding mental health services. As outlined in Charter 2020, there is strong support across the mental health and suicide prevention sectors for a new national agreement as a fundamental reform on which other improvements are based.

The Commission has also included recommendations to increase early intervention and prevention, such as greater engagement with schools and universities in mental health and wellbeing. These recommendations need further development with stakeholders, but we support the initial thinking around increasing early intervention and prevention as a key component of reform.

Today, we'd particularly like to discuss the Commission's three key elements that Mental Health Australia perceives to be missing in the draft report. We believe these components to be critical, and suitable ambitious - for a suitable ambitious reform agenda that will create once in a generation change in mental health. These are: firstly, articulating an overarching vision for the mental health system, fundamentally focused around recovery.

Secondly, addressing the missing middle in the mental health service system through increasing community-based and psychosocial support services; and thirdly, establishing governance structures that ensure accountability for governments addressing existing gaps, and support genuine consumer and carer co-design. The recommendations of the final report must be deeply considered and thoroughly costed so the implementation is not only feasible, but almost obligatory.

It is difficult to get a sense of the overarching narrative and the draft report. The end goal is unclear. The Commission includes an analysis of the number of people who will require different types of care in a Stepped Care diagram. However, this does not outline a vision for recovery. Could we reduce the number of people who need high intensity care by increasing service availability and quality? Are we aiming to just better manage the static epidemiology of mental illness, or to increase social and economic participation?

We would encourage the Productivity Commission to ambitiously articulate a vision for a cohesive mental health system and clear consumer pathway that are centred around commitment to recovery. Related to this is our response to what has become known as the 'missing middle'; the gap between primary and acute care. Again, while the draft report includes considerations of this issue and the reasons behind it, the proposed solutions are less clear. The draft report does not include a sound understanding of the whole government sector, or the service sector, both clinical and psychosocial, that could further populate the space between primary care and the emergency department.

Psychosocial services in particular seem to have not been well understood, and painted largely as being engaged only once clinical care has failed. The Commission has recognised the need for longer-term contracts for psychosocial service providers, but seems to have a narrow view as to the role that could be played by these organisations. The role for new community-based clinical and psychosocial services in keeping people out of hospital should be more fully described.

Our vision for supporting mental wellbeing and participation is fundamentally tied to government structures. The proposed new governance arrangements in the draft report would leave responsibility for psychosocial services split, with the Australian government managing these for NDIS recipients, and the states and territories managing the rest. The Commission's preferred proposed model is that Commonwealth and state territory funding for mental health care, psychosocial supports and carer support services be pooled to new regional commissioning authorities to manage these services at a regional level.

If this model is accepted, a clear priority for these regional community authorities must be to properly invest in community-based services, rather than just in primary and acute care. Many would suggest this investment is the key to shifting Australia's mental health. We must also be committed to ensuring that everyone is able to access the services they need, no matter where they live. Any new governance systems must be orientated to the lived experience of consumers and carers.

The draft report has a welcome focus on consumers and carers, seeking to place them at the centre of a system change. However, these need to be further - there needs to be further appreciation on the resources and structures needed to enable this to occur, with care representation occurring across the mental health sector. We need to drive new thinking and new planning in mental health.

While much of the draft report suggests innovation, many of the recommendations rely on existing people, groups, and structures that have been involved in mental health for decades. The final report could include, potentially, best examples of co-design. Our colleagues in the Embrace Multicultural Mental Health Project have particularly highlighted to the Commission the need for better engagement with mental health consumers and carers from culturally and linguistically diverse backgrounds.

Thirty per cent of Australians are born overseas, with at least half of those having at least one parent born overseas. Our mental health services need to reflect and respond well to cultural diversity, including in these the First Nations and LGBTQI people. This is not reflected strongly enough in the Commission's recommendations.

Thank you again for the opportunity to speak to you about this incredibly important inquiry. The draft report provides a solid foundation and outline of the challenges facing us. We look forward to working with the Commission to further develop the recommendations to ensure the final report sets out an ambitious reform agenda to make lasting improvements in the mental health and social participation of Australians. Thank you.

PROF KING: Thank you, Mr Lovelock. Let me lead off the questioning, and I'll start with the last part. So a couple of question just on the structures, and particularly being consumer and carer representation in. So, as I understand, we put up the two models. The RCA versus the PHN, LHN type model. I think you said you prefer, at this stage anyway, given the details, or lack of details, you prefer the RCA model; is that - - -

MR LOVELOCK: I don't think we've come to a position on that. I mean, it's just we've recommended - the Commission itself said it was the preferred model.

PROF KING: Yes.

MR LOVELOCK: So it looked at that as a preferred model, but at this stage, we haven't had a chance to consult further with the sector.

PROF KING: Okay. The NDIS services; you've said psychosocial services for NDIS that they would also have to be part of the same structure, however - whichever structure is used for psychosocial supports for non-NDIS mental illness.

MR LOVELOCK: Yes.

PROF KING: Your view is they have to be the same across the two?

MR LOVELOCK: Well, not necessarily. But there needs to be some integration to enable - to ensure that there's cohesive provision of services. I mean, already we're struggling with -

the sector's fragmented, and they have been - particularly faced a difficult time in the implementation of the NDIS, around maintaining service delivery in the workforce. And we don't want to get in a position where that's further fragmented by a split between different - further splits in funding systems.

So even if there are different funding providers, there needs to be some mechanism that enables cohesion to occur for those service providers, which is, at the moment, quite problematic for them.

PROF KING: Yes. Thoughts on that mechanism? I mean, we've obviously heard from the provider sector about the issues they're facing not just in the NDIS, but even outside the NDIS with the PHN structure as it is at the moment. Your thoughts on that?

MR LOVELOCK: Yes. I mean, it's still early days in the - in the whole implementation of the NDIS and the work of PHNs. They're still coming to terms with it. The NDIA has been - there's been considerable improvements around that space, and I think the recommendations you've got in here are very - are positive around the provision of psychosocial support services to people, whether they're in the NDIS or not, and it's really just enabling those funding structures to follow that and enable it to occur.

I mean, in some ways, that touches on a bigger issue around the funding mechanisms themselves for mental health in which, at the moment, I think the emphasis would be on funding existing medical type services through hospitals and health professionals, whereas we think there should be consideration, as we put into our submission, around the use of the different types of funding models that could incentivise shifting towards community - more community-based service delivery.

And that's a very complex issue, I know, but it has - there are overseas examples which we've provided in some of our submissions that could be looked at, particularly a value-adding model used in New York, and I can't remember some of the other models in there, but I think the Manchester model was another model where they looked at commissioning agencies and grouping - bringing groups together to look at commissioning the services, which is something I know the PHNs have been charged to do.

But I think the general feeling is that that hasn't occurred to date, but they're still really tendering services and not really undertaking that full commissioning process which brings groups together to look at how better to fund. And that probably needs to happen on a grander scale to really make a difference in the mental health system.

PROF KING: Is there a fundamental problem though, if we want services provided on a regional level, but many of the service providers will operate over many regions. Is there always going to be a tension there, that service providers will necessarily have different requirements, be it the answering to different bodies across Australia, or is it that the regional - or is the regional approach wrong? I'm not sure how we solve that issue. It seems a tension there.

MR LOVELOCK: I mean, I haven't got the answers to it. I know it has been - the general feeling is the principle of regionalisation is one that's well accepted and regarded as a positive thing to do; that you need regional solutions to deal with service delivery. But it also does provide significant issues for providers in managing, you know, 31 different networks without a mechanism of that being more coordinated.

And with all the different reporting mechanisms, you know, that's certainly something that comes up regularly from the sector, is the amount of reporting they have to do in relation to all these different contracts that they have to maintain across all these different areas, adds to their burden of cost, which again reduces capacity to deliver services.

PROF KING: Okay. And just one more before passing over. Sorry, I've (indistinct) the discussion. You mention consumer and carers - by the way, thank you very much for your initial feedback.

MR LOVELOCK: Thank you.

PROF KING: I think you went through every one of our recommendations - - -

MR LOVELOCK: We did.

PROF KING: - - - with feedback, which is - - -

MR LOVELOCK: And I must add, the majority we have by far supported, so - and the others we just need more information on.

PROF KING: Thank you very much for that. Well, it was an impressive effort to be able to get that turned around so quickly and give us feedback, so thank you. We really value that. One of the things you mentioned there, and also in your comments this morning, is the consumer and carer representation across the mental health sector, and co-design. And again, I guess one of the issues we have struggled with is how to embed that in a way that allows flexibility.

So from our perspective, we're saying, well, if you've got regional bodies, do you leave it up to the regional bodies? To what degree do you give them some guidance, or to what degree to you become prescriptive over the regional bodies? And I can see costs and benefits of each of those. So just your views on that, and where you think we should be going?

MR LOVELOCK: There is a process in place, I believe, where the Consumer and Carer Forum and others are looking at consumer co-design to come up with some models around that. Personally, from my experience, the models we've got in place at the moment are too static to deal with the type of feedback we need to get to get good consumer feedback. We need to look at more dynamic models of engagement, using other means than committees and organisations to engage consumers and carers, if we're looking at representing the whole sector.

With one in five people in Australia, it's a significantly larger group than traditionally who have been representing consumers and carers in the more acute sector, and I think to really design, we need to broaden that out using a whole range of different mechanisms, both electronic and otherwise, market research and other mechanisms to get that sort of feedback and a timely way to enable that to inform design principles.

PROF KING: Okay. Julie.

MS ABRAMSON: Thank you. Like Stephen, can I also thank you for the really constructive way you've engaged with the Commission. It's really been extremely helpful, so thank you. I wanted to ask a bit more about your comments around care in the community and community participation, and certainly when we've spoken to you previously, you've spoken a lot about that, and we're really interested in what you think that looks like, and I'm also interested to have a bit of a conversation around funding, although we appreciate we'll have other conversations. So really interested in that.

MR LOVELOCK: Yes. I mean, MBS is a fantastic mechanism for getting services to a large number of people in a timely way, and giving them choice around who they see and provide. It's got built-in problems around coverage, because it's very much provider driven. And so community-based mental health services that are funded, that enable people to engage and provide services in areas that otherwise would not be covered under an NDIS model, I think is something that is worthy of consideration.

And it's something that I think has previously been provided, but over the years has been reduced through state government investment, primarily, I guess, in response to other investments that have come elsewhere through the Commonwealth system. So there's been a shifting of service provision that's left a gap. But also, we think there should be incentives in place to enable that shift into more community-based services that are more early intervention focused, so enabling people timely access, and you've touched on some of those in your own - in your recommendations around, you know, looking to provide access to electronic types of interventions.

And while I think they will certainly fill a significant gap, I think people living in rural areas, and even outer regional areas, still value face-to-face interventions as well, and there needs to be looking at some mechanisms to enable that to occur. And the same with the psychosocial area. The role in those services in both maintaining people in the community, in terms of early intervention, is part of that Stepped Care Model.

I think it needs to be further emphasised and looked at, because from my understanding of the research, it generally shows that if you can get people early in their phase of illness, you know, during an acute period, as early as possible, you'll more than likely be able to stop them from ending up in a clinical environment, and that's going to be a cost saving in the long-term.

MS ABRAMSON: Mr Lovelock, could I press you a little further on that? What would that actually look like? Like, I mean, we had some idea, but what are the types of services you want to see in the community? Because you did mention previously there had been other programs, and now they're not there because of the change in funding. So really interested in that.

MR LOVELOCK: Well, the community mental health services, if you look at the data, have shifted a lot to now very short telephone interventions.

MS ABRAMSON: Yes.

MR LOVELOCK: Primarily, I think, by managing medication or other matters, rather than providing an opportunity for people to come to talk to somebody to deal with or potentially coordinate and help case manage issue that they're facing, and that primarily will be around housing, employment, their relationship based issues. Those sort of services are more and more difficult to find, and as a consequence, there isn't support in the community for people who have more complex mental illnesses that might otherwise be maintained there, rather than becoming - coming into the emergency department, which is a high cost.

MS ABRAMSON: So, to follow that up, as you know, we've got a number of recommendations through our mental health nurses, but I guess what you're saying to us, well that's the clinical side of people operating in the community, but you're talking about the psychosocial supports.

MR LOVELOCK: Correct. That's right.

MS ABRAMSON: Yes.

MS HATFIELD: We've been talking a lot as well about what are the kind of services that fit between - yes, the acute care and people who need - who have mild to moderate mental illness, but that gap in the middle, and that is the community services that are more holistic, and can engage with a person flexibly, in desperate needs, and we think the sector as well can do a better job of articulating what those services are, and as we consult with the sector to get out response to the submission, we'll be looking to do that as well.

MS ABRAMSON: That would be incredibly helpful to us, in your follow up submissions, and also highlighting some areas where you think - you did mention some overseas examples, so that will be very helpful for us.

MR LOVELOCK: We've got a member policy forum happening on 26 November, that Stephen, I think you're presenting at the oration the night before. But if there's particular issues you'd like us to raise with the sector during that forum, we're happy to put those to that meeting as well.

MS ABRAMSON: Look, thank you. I think the psychosocial supports, like where we've had - I think we can certainly say this - we've had quite a bit of feedback around that, and we're really keen to understand what it is that you think would be good in there, and also we started to have a conversation a bit about funding.

If I could turn to another issue, and this was reflective of conversations we've had with you with CALD communities, and we did observe that we knew that some of the online services, or Lifeline, I think, said to us that there was a difficulty in working with different communities. So we are really open to ideas about, well how do we get services to such a disparate range of community groups. So never wanted to give the impression that that wasn't an area of focus for the Commission. It's just that we really would need some assistance as to what you think that might look like.

MR LOVELOCK: We're happy to raise that with the Embrace team and get them to provide some more information to you as part of our submission, if you like.

MS ABRAMSON: That would be very helpful. Thank you.

PROF WHITEFORD: Hi. So, I guess one of my questions is around psychosocial support, to keep it going. That to me, and what we've heard, is that it means different things to different people, and so psychosocial support for people with what we would call complex, more severe mental illness is very different to psychosocial support for people with early symptoms, or at risk, or have milder, clinically milder conditions. So any feedback or any advice about how that non-clinical intervention fits across some sort of Stepped Care approach, where Stepped Care has traditionally been carved out depending on clinical severity, perhaps.

But clearly the feedback we're getting is that while someone might have clinically a less severe, if you want to put it that way, mental illness, the psychosocial issues at that stage, if they can be tackled, would do a lot to prevent any clinical worsening of someone's condition. And that's a different package, from what we've been told, to someone who's had a more established mental illness diagnosis. So that would be very valuable.

MR LOVELOCK: I mean, initially, some of the informal discussions we've been having is around how to better support GPs in that process. I mean, GPs are, without doubt, the central contact point, and - but they have varying skills in this space. Education and training really hasn't been successful in the past, so I'm not sure that's going to be successful in the future. But maybe co-location of people who have a broader skill-base than just the health model working with GPs might be a useful and a good point in engagement, where GPs can refer off or refer to that might be useful in that process.

And they might even be the person - you know, we've talked about who owns the care plan. You've talked about whether it's the GP, or it may not be. It might be the psychosocial service provider who actually holds that, or it might be somebody who's working or co-located with the GPs in that space. But I just think we've got to look at a bit of a different model than what we have in the past, because it really hasn't worked that well to date. But yes, we're happy to provide further information on that space as well.

PROF KING: Yes. Sorry, yes, finishing with that. Yes.

PROF WHITEFORD: And also I think, for us, staying with that just for one more question around children and youth and families. Again, the psychosocial support that's needed then, before anybody makes a diagnosis or anything, we've been told is very important in intervening early and prevention. So any feedback or advice you can give us around that would be also valuable.

MR LOVELOCK: Sure. I mean, as you know, the MBS is a problem in that space, because you can only deal with the person in the room, and obviously there would be family issues that would come up as part of, you know, interventions where providers have a difficulty in engaging further, and that's an issue again with the MBS and we probably need to look at how to make it more flexible to enable some of those more family interventions that are provided, because that's certainly something that we've touched on as well, and we're happy to provide more information.

PROF WHITEFORD: Thank you.

MS HATFIELD: The other thing I would say is that the - looking at other professionals and that kind of team-based care, so - and the increasing of peer workers that provide a particular kind of support that is different to clinical support, and that's, yes, a really important area and an opportunity for growth and to, yes, partly meet this need for increased psychosocial services, I think.

MS ABRAMSON: I mean, I'm sure you would have noticed this, and I don't want to put words in your mouth, but I'm sure you were supportive of this. We've said quite a bit about peer workers.

MR LOVELOCK: Yes, which is great. Absolutely, yes. Well recognised, so that's tremendous.

PROF KING: So one of the bits of early feedback that I've had, not just here, but also talking to some others, is that not just that we have to much more clearly embed psychosocial supports with the clinical supports, giving them, for want of a better word, equal weight in the approach, recognising that they are a package. That clinical is not going to be effective without psychosocial support, nor vice versa, and I take that on board. And also, across the spectre. So not just simply down that acute end, or even the moderate end, but even going down to the mild end.

And I can see that from other work I've done. I can see the importance of - I think you mentioned housing, employment, relationship issues. Financial services is one I've come across elsewhere. I guess, from our perspective though, we're faced with an issue of how long is a piece of string. Where do we actually draw the boundaries between the mental health system and the supports that many people need who are maybe feeling stress, but do not have a diagnosed mental illness, but are facing stress in their everyday lives.

Where do we draw the boundary of that? Because I see a risk there, that we're drawn into, well let's redesign Australian society and - - -

MR LOVELOCK: That's a good place to start.

PROF KING: Except you may end up having the mental health recommendations swamped by debates about, well should we have free financial counselling and so on, and you lose the war by trying to win a different battle.

MR LOVELOCK: Harvey will obviously put his head down - how many times we talked about this in the past, because it's a big issue. Are we talking about mental health or are we talking about mental illness? I mean, because mental health goes across all facets of our life. Mental illness is the result of where your mental health deteriorates to a point where you need intervention.

So again, I mean, I don't think there is a clear answer on that. It is grey, and I think what we need is flexibility to enable to have some control over that, and enable the system to be robust enough to have some capability to refer people to different aspects. I mean, we've talked about the problems with having Care Coordination when you haven't got any services to refer people to, and at the moment, I think there needs to be a bigger investment in the types of services that provide that flexibility, which there isn't at the moment.

Or even better integration with those that are there. I mean, we didn't talk about family support services provided through DSS. I mean, they've got their own systems of support that are available as well. But how do you integrate that? How do you get from one thing to another? The Stepped Care Model we've got at the moment, while there's some significant services in there, getting from one to the other is a very complex process, and I think that is not - that's just within the mental health sector, but there's also those other aspects of finance and education, employment, housing, that are all silos as well.

Getting across those is very difficult, and that's why we've talked about that initial area of governance, and how to get that broad governance and engagement across government to enable those discussions to be held to try to reduce those boundaries that prevent people getting across different silos of services. And mental health is a really good example of that needing to be done.

PROF KING: So we obviously should talk about Care Coordination. Again, we were focusing more down the severe, moderate end. Down the more mild end, is it really that there needs to be, in a sense, another system separate from the mental health system that provides relevant supports for people in society, but there is a linkage back into - and you mentioned GPs, for example, you've mentioned peer workers.

That there's a linkage back to the people who go to the GP because they're feeling stressed. They may have had a panic attack, or something like that. But they can then be linked into this alternative system, or this outside mental health system. Because again, I get a little bit worried about the tail wagging a very big dog that could - - -

MR LOVELOCK: Yes. I haven't got an answer to that, Stephen, but acknowledge it's a tension. I mean, I do think there's a lot of things we've got that could do better. I mean, the Head to Health was a great example of what was to be a sort of a - a touchpoint of people who have low and very mild symptoms, to get them further information, more around the psychoeducation aspect, that was initially to enable them to engage other service providers, to enable first contact if they need more.

But it's really become more of a static website, and that was a bit of a lost opportunity in there. Now the use of Care Coordination that we've talked about could potentially be built in electronically to some of these platforms to make it more accessible to people who are experiencing first-time anxiety, or problems in dealing with their mental health. And again, that sort of requires a bigger picture than just the health picture. It's really somebody who can look at the broader areas of need according to what the person's issue is, not what the trajectory of a potential mental illness is.

PROF KING: We recommend navigation portals for service providers.

MR LOVELOCK: That could work. I'm not sure what it would translate to, but I think anything that provides greater use of electronic platforms that enables improved engagement is great, and we should be doing more of that.

PROF KING: Okay.

MR LOVELOCK: It's been more difficult in the past to deliver on these visions, unfortunately, when they get into the dilemmas of how do you manage privacy and confidentiality and other matters, and the actual mechanics of developing IT systems can sometimes undermine the original intention of what these were. But I think we should be looking for more of those.

MS ABRAMSON: Can I, just in concluding, because we're nearly out of time, anything that you'd like to bring to our attention in the submissions would be really helpful. So you've talked a bit about, well, there were some programs in the past that did this, and also your overseas examples. Did you want to make any concluding remarks?

MR LOVELOCK: Only that we believe that the Commission has done a fantastic job in getting to the point that we're in.

MS ABRAMSON: Well, we like that comment.

MR LOVELOCK: And we agree by far with the majority of things you've done than less, but in terms of emphasis, we just think - as I say, we're certainly happy to talk to the Commission about this. It just needs something a bit grander in terms of a system of mental health that we're looking to, not necessarily in one or two years' time, but where we might be headed in ten years' time, to really address the fundamental issues that we're facing now, and that to give it a vision towards something we can work to that's incentivising greater community engagement to try to reduce clinical and hospital interventions.

MS ABRAMSON: Thank you.

MR LOVELOCK: With consumer care and co-design as the basis of that.

MS ABRAMSON: Yes, and we will talk to you further, anyway.

MR LOVELOCK: Yes, okay.

MS ABRAMSON: Thank you so much.

MR LOVELOCK: Thank you very much for the time.

MS ABRAMSON: Thank you.

PROF KING: Thank you for joining us from Mental Health Carers Australia. Would you be able to state your name, organisation - which I've just stated. If you could state your names and organisation for the record.

MS ARMSTRONG: We're from Mental Health Carers Australia. My name is Katrina Armstrong and I'm the Executive Officer.

MR COGGIN: And I'm Jeremy Coggin. I'm the President.

PROF KING: Fantastic. And do you have an opening statement you'd like to make?

MS ARMSTRONG: Yes, we do.

PROF KING: Please.

MS ARMSTRONG: All right. So first of all, we'd like to thank the Commission for this opportunity present at this hearing. For you benefit, Mental Health Carers Australia is a national peak body focused solely on the needs of mental health families and carers. We're made up of seven state and territory organisations, including one national. Our state members are Tandem Victoria; Mental Health Carers NSW; Mental Health Families and Friends Tasmania; Arafmi, Queensland; MIFA, NT; HelpingMinds from WA, and Mind Australia, which is a national organisation.

As you can see, we have an extensive reach across Australia. Every day, we're supporting and speaking with mental health families and carers about their experiences of the mental health service system. Our submission to the Commission in April was based on feedback and information provided to us by the many thousands of Australians supporting someone living with mental ill-health. Last week, we hosted a sector roundtable to discuss a coordinated response around family care issues to this submission.

We came together because we believe that a strong and effective mental health system will have at its core the very people it's designed to support. We want mental health reform to embed person centred principles with individuals, their families, and carers involved in all aspects of service design, and we heard earlier from Mental Health Australia about co-design. We want to see services that respond to the individual needs and preferences of people, and not people fitting into an inflexible and uncoordinated system.

We see this inquiry as an important juncture in mental health reform. It presents a once in a generation opportunity to see real change in the way that mental health services are funded and delivered, from early intervention and prevention to acute care. We note that for many people, their families and carers are with them at every step of their journey through the mental health system, and on their journey to recovery. Both people who are living with mental ill-health and their supporters deserve better, and be afforded the dignity and recognition that has been lacking for so long.

So that's our opening statement. We'd also like to say that we are a signatory to the Charter 2020, and we fully support the Time to Fix Mental Health campaign, and that (indistinct) Mental Health Australia around the launch of that campaign. Our aim is to work constructively with government to improve policies and programs that directly and indirectly impact the families and carers of people living with mental ill-health. I will hand over to Jeremy, who will raise, I guess, the first issue. We'd like to say that, just initially, broadly we're comfortable with the recommendations made about carer income support and employment.

I guess the only note of caution is that carers do provide significant amounts of time over the phone, or supporting people outside their homes. So I think that recommendation in relation to the carer payment just needs to be monitored to make sure that carers who don't necessarily live with the person their supporting, but still provide a significant amount of coaching or support over the phone, and attending appointments outside the home aren't unfairly disadvantaged, and at this point in time, we don't have a set position around the proposal to shift carer support services to the states and territories, and we have some reservations about that.

But in the first instance, I'll hand over to Jeremy.

MR COGGIN: Great. Thanks, Katrina. And Katrina and I are both - we've put together a combined response that incorporates from the roundtable work last week some key recommendations, which we'll also put through more formally. The component I want to talk about really touches on, essentially, how do we - how can the Commission lift the voice of the carer and families and friends in the report, the final report, and more importantly, translate that voice through to integration or action that will leverage or empower both consumers and carers for better outcomes.

To that point, we acknowledge the reference and inclusion of family carers throughout the report, and in fact, the dedicated Chapter 13 for families and carers includes a really strong summary of that critical role. I think we were very heartened by that, and in terms of even the summary on the first page, it kind of gets it right. However, when we get to the end of that chapter, and we see the recommendations, it's very light in terms of the depth that is covered, and in fact, whilst the recommendations thereto primarily are on MBS and the care experience survey, concept around building knowledge of carers, it is essentially silent in translating there and further up into the recommendations and reforms of much of the guts that you actually highlight.

We're used to our voice being silent. We're used to family and carers being hidden, and in fact, the summary of your chapter acknowledges that as well. And then in terms of that silence, maybe in connecting through with - you mentioned the earlier point around starting to try and unpack this concept of psychosocial, which is community-based supports, and we get a double whammy where, as you're now understanding this divide between acute, subacute, and community-based services, exacerbates an integrated response that ultimately actually prevents mental health escalating from the mild to the extreme.

The double whammy for family and carers is that's where a lot of the work also happens for family and carers, and so whilst we don't solve that one, it's almost as if family and carers then are the next cab off the rank to come after that. So to that point, we're asking that a key request would be, could you simply revisit the detail you have in that chapter and look at opportunities to translate that up within a number of the reforms and recommendations.

Some of the questions asked at the roundtable was, when we see that gap of translation up, is it possible that, on some level, was there - it's almost like was there a find and replace for consumer in the summary report. Find and replace, and let's add family and carer. Now we are very used to it, because we - I've been in board roles in the psychosocial set for eight years, and I myself see that's one of the way we handle it in terms of the really scant or stretched funding services we have as it as.

So it's always the next thing we'll get to, at some point. But we don't get to it. So to this once in a lifetime opportunity, we're really keen that you could help do that work for us to lift the voice, which includes in your opening summaries in the recommendations and key points, can we see that voice in there? Now, to touch on some other recommendations around the voice, we heard the conversation in terms of the co-production or co-design.

We're very keen that there would be a more explicit reference to a mandated framework of family and care inclusive, and consumer inclusive, co-design that is used across multiple settings when we develop service design and policy. There are actually components happening already, and in fact, MHCA have, I think, had some success in line with - in partnership with Carers Australia and the Private Mental Health Carer Consumer Network in terms of some work on the carer pathway in the new mental health stream of NDIS. And I look across to MHA because there has been also a broader piece of co-design.

So we're seeing the pockets come through; the opportunity is to elevate that where it is mandated in the context that all providers have to start to work through how do we design services and systems which include the voice of the customers? I, myself, work in a corporate context in my day job, and that is actually what corporates are doing: we are needing to incorporate the voice of the customer. And with that comes cost or funding, but it also gets a better outcome.

The second point in terms of inclusive practice is, we would like the report to be stronger about ensuring care-inclusive practice is not voluntary for service providers; it's a mandatory, and it used to set standards, accreditation, compliance regimes, where, once again, family care is not an add-on, it is integral to a combined response that gets the best outcome for all parties.

We have the Family and Carer Guide, which the Mental Health Commissions in WA and Tassie are currently trying to scale-out at a state level, but without the clear mandate we hit the same problem where we've got other priorities we have to get to first. So the intention is there, but ultimately, it's an optional.

And lastly, in terms of us lifting the voice and the final report, it's great to see that push around lifting awareness of mental health, lifting prevention measures, and where key in that also to make sure the family carer is integral in that increase of awareness. And in fact, in terms of early intervention phases, when often it's very new for family carers, that there is also an increased waiting at that point when it's new for everyone, trying to understand what's happening.

To that point, you've heard me connect to this relational response, and I'll pass back to Katrina for that part.

MS ARMSTRONG: Thanks, Jeremy. So in our submission, we talked about recommending a relational approach for recovery, so to that point, what we'd like to see in the final report is a greater focus on social and relational approach to recovery, mental health, and that strongly considers the social and economic determinants and the relational aspects of mental health.

A social model recovery approach to mental health would place the person at the centre of these supports, with a greater focus on the wellbeing of their most important interpersonal day-to-day relationships. And we touched on this issue around psychosocial supports earlier, with Mental Health Australia.

But we note on page 6 of the draft report that you say that:

> *Focus on clinical services, which often overlooks other determinants of, and contributors to, mental health, include an important role played by carers' family and kinship groups and providers of social support services.*

But when we come to the recommendations, Part 1 - and this is in our comment around the way the report is structured, and you did refer to that around, you know, giving things due weighting, but the first part of the report in terms of recommendations focus on, you know, the clinical or the healthcare aspect of mental health, with the psychosocial supports coming second. So we'd probably like you to look at how that's structured, so that the whole life, the person's whole life, as well as their clinical services, are given sort of due weight, so to speak.

So our view is that clinical interventions that fail to address the root cause of mental illness, and that do not take a relational-based approach to recovery - so a good example if you applied a relational approach in clinical settings is Open Dialogue. We'll be doomed to fail if the person returns to a day-to-day life where there is no meaning and no hope. Mental health reform must address the needs of the whole person and the most important relationships, and we'd like the Commission to explore how this can be incentivised throughout the health system and community-based services.

For example, you could propose incentivising the expansion of proven relational-based health programs such as Open Dialogue, that does have an evidence base. We'd also like to explore how the broader sector could be incentivised to innovate; for example, we've heard anecdotally about sort of different models: care farms came up as part of our consultations as a great example, which made a sense of contribution and responsibility for vulnerable people.

I guess we're a little bit disappointed this hasn't been addressed as extensively as we'd like in the report, and I think as Harry rightly pointed out, you know, it seems to be sort of more of the same rather than a complete sort of re-review of everything. We know it's not working; our system currently isn't working. I know that you need evidence to be able to support changing the system, but what could be trialled and tested, or you know, dedicated funding to evaluate things that we've heard anecdotally are working that could be potentially scaled-up more broadly, to give people a meaningful life.

And I think that's where there are parallels, so around the psychosocial supports with the NDIS. I think we heard throughout our consultations as part of that project that the NDIS was offering, I guess in some ways, support similar to PIR; it was looking beyond clinical to the person's whole life, to establishing relationships, to re-establishing relationships, to employment; to all the things that we want in our day-to-day life, that people have access to the same social and economic opportunities as everybody else. So we would argue that that needs to be first and foremost in mental health reform.

So to achieve this, what we'd like to see is vision; I think similarly, we would like an articulation of the vision upfront in the report. So what does a good mental health system look like for people? So again, not just on the clinical side, but what does mental health look like for all people? And I guess to consider whether existing funding arrangements, including the governmental split in responsibilities are contributing to or detracting from such a vision being implemented.

We believe that setting a vision upfront would provide a set of foundational guiding principles for how funding in investment decisions are made. So rather again just more of the same, it's what are the principles underpinning mental health reform, and then how does that actually guide where government invests the dollar?

So just another comment we'd like to make is around the consumer and therapy workforce. There was quite a bit of references in the report about the key workforce in general, so our proposal was that you know, we're arguing for a national therapy workforce, support people at all stages, from early intervention, right through to acute care.

Families and carers are struggling often to navigate the system, they're often dealing with a new language and a new culture. I receive emails every week from people out there in the community - that may not even be at this point connected with one of our organisations - who are saying, "I don't know what to do. I need support, I need guidance. I don't know if anything I say or do is going to negatively impact the person that I am trying to support." So there is a lot of fear and a lot of uncertainty for those people.

The other comment around the co-design is that we also proposed that the Commission recommends the establishment of a framework to support that; so rather than just launch into co-design, that a national framework should be developed that guides governments and service providers on how they can go into co-design and co-production processes with consumer and carer groups in an authentic way. But I think the first thing that needs to be done is to actually develop a framework around how that is facilitated.

PROF KING: Okay, thank you for that. Can I, in a sense, come back to that last point, which in some way ties back to your first point, the issue of co-design? And I get concerned about a national framework, in the sense that if we're after regional approaches to psychosocial support - let's assume that it's embedded in with the clinical services, and that's made very clear, and we've heard that message - we still want regional solutions, so whether it's a new commissioning body or whether it's the PHNs co-ordinating with the local hospital districts.

And so we need the flexibility to have consumer and carer input at that local or that regional level, and so I guess I get concerned that a high-level national framework is going to have to be - you know, it may not actually help very much on the ground. So I guess how would we implement that co-design on the ground; would it be restrictions or requirements on the governments of the commissioning authorities; would it be restrictions on the NGOs or the other service providers, that could apply for contracts or the commissioned services; would it be a separate body that is created?

Really, just how do you see the mechanics working on the ground in regional areas?

MR COGGIN: Can I answer that?

PROF KING: Please, yes.

MR COGGIN: In my day job, in terms of the corporate domain, co-design is actually about personalisation, and regionalisation is a bundled-up group of personalisation.

PROF KING: Yes.

MR COGGIN: So I think there is not attention around co-design and regionalisation; in fact, it would enable and empower regionalisation.

But to your point, it is around governance, I think, essentially. And if it's governance about the actual customer is included in the service design. For me, when I came into the sector from a board perspective eight or nine years ago, in the context of my strategy expertise, what was striking for me was what is essentially a block-funded environment. For me, my observation was service providers, their primary client was the government, and whilst the mission and passion for family or consumer and family outcomes is foremost, the actual design of services is ultimately in the context of government, and a government-funded model.

So that is actually powerful about NDIS in that shift to a consumer model and choice and control is, it forces the design where the customer - the consumer and the carer - are part of the solution. And that is obviously one of the hypotheses. So for us asking for the family carer framework, if it was even a set of principles - because the question would be how much of a stick would you be able to mandate or want to mandate?

Even just if there's commitment to a national agreement for mental health in Australia, for us, it would be very simple for there to be a national framework which potentially says, as a principle - if I just go to the most basic level - at a principle, any service design in your domain includes at least some family and carers, and at least some consumers. Just that would actually be an improvement.

But obviously, you would ideally co-design the framework with consumers and carers, and service providers, because they are also a customer in that component, and you're providing this constraint about it clearly needs to be workable. And so I think for us, it's a bit like getting a foot in the door. I think where you've been using the care experience survey, I think as an opportunity to get a foot in the door, which is interesting: we recommended a similar piece for the psychosocial stream and NDIS, because we thought well, if these just captured data, at least people can start going, "Oh, there is a correlation." I note, there are; it makes a difference.

So from the framework, if we could get the foot in the door of a framework, even if it was the principle of it, at least it would give - and in that part, the other principle might be, there will to be funding in the design that incorporates that inclusion of the - well, I'll just call them the customers - in testing the product.

MS ARMSTRONG: I think also - sorry - co-design and co-production are relatively new concepts, and so it's also a relatively new discipline. And I think there is confusion about what those terms mean and I think there is a risk that you know, commissioning bodies, as an example, could say, "Oh yes, we went through a thorough co-design process," but it might've been consultation.

So there is a continuum of what, you know, consultation, right up to co-production. And each step of that, you know, they're starting to define each step up that continuum, what that looks like. So co-production is actually creating policy together; co-design is a step back, where you're designing what that sort of looks like, or the implementation. And consultation is, "What do you think?"

So where we were proposing a national framework is that given it's an emerging discipline, and given the risks that people will say, "Well, we've gone through a co-production process," but in fact, it was consultation, is that developing an overarching framework would support those commissioning bodies - including governments and potentially service providers - to say, "Well, actually, here's the set of guiding principles."

And best practice. So here's the example of governance structures that you could establish that genuinely support co-design processes. Here is an example of, you know, the principles that would underpin the development of co-design policy or service. The governance or steering committee would need to consist of X many customers on that governance and steering committee.

So that would - given it's an emerging discipline across every state and territory, and at a national level - provide some guidance on how to do that, so people don't run the risk of saying they've been doing something and in fact, been doing something entirely different.

MR COGGIN: And then for us, the family and carer is in there.

PROF KING: Yes.

MS ARMSTRONG: Yes.

MS ABRAMSON: I just had - and you may want to take this up in your submission - I was quite struck, Mr Coggin, when you said you've laid out the issues in chapter 13; but what was it that you would be recommending that we go further in? So you said, well you've sketched-out the problem, but then we were looking for something at the other end.

And I just want to make one comment: one of the difficulties in the carer area for us was that all of the social security type payment systems and everything deal with carers in the broad, and the Commission was quite cognisant that it was actually dealing with a narrower lean. But in your submission, we're very interested in what you think that would be more helpful.

The other issue I'd raise with you too is, one of the issues for us is that - and I'm not putting this as right or wrong, just putting it as a proposition - the legal system starts with the consumer themselves, so when they're in the hospital setting or the medical setting, they're the consumer. And we're very open to ideas that might be put to us about how the carers can be more involved, because I know that we were told that one of the difficulties is that the hospital would say, or the medical professionals would say, "Well, we're not authorised to tell you that." And we heard that very clearly from carers.

But we're quite interested in the mechanisms as to how you think that that could be improved.

MR COGGIN: And I think well, then you talk to a challenge, because I think in a way, your PC response is dependent on our submissions. I mean, it's that double whammy of the psychosocial conversation.

MS ABRAMSON: Yes.

MR COGGIN: I think for us, it goes to this conversation around relational and how we're positioned as part of the problem and part of the solution.

MS ABRAMSON: Solution, yes.

MR COGGIN: But I think we're often positioned as part of the problem. And of course, consent is critical from the consumer; if the consumer does not want to consent to the inclusion of direct family, they will still have support, or many will still have other friends or support mechanisms.

If I connect to our NDIS work we did, that was the core tension there too: it's designed for the participant, and NDIS has a challenge where they actually have to - we know the outcome is better for the participant the more there is inclusion of a relational approach, and so how do they balance that tension? In terms of my role on Mind Australia, we have a thousand staff; many of our business are transitioning into NDIS. And more people than not are very happy to include family and carers.

So really, our key request is that inclusion, so in all of your recommendations - it's actually fantastic you might've done the find and replace and added family and carer; it's actually great, because that is a big shift. But one - - -

MS ABRAMSON: Try and resist.

MR COGGIN: The question for us is, how do we bring it out in the detail? And to be honest, that, for us too, is I think - because we've been silent, I didn't even know my family or we fit the criteria of carers. I think we're still very early in our maturity to assert what it looks like; I mean, that's one reason why we go to the co-design model, because at least there, it forces that voice in the service design. And we certainly know we need to go through the report to now look at the elements you have, how do we translate them up?

So I'm not giving you a clear - there are multiple services we can talk to; we know Partners in Recovery actually was a co-designed service that has been defunded. So there are simple examples - and that was relational - that we can connect through.

MS ARMSTRONG: The other mechanism that we proposed, we do have a practical guide; so we've referenced that in our submission as well. So the practical guide for working with carers of someone with mental illness. And that provides six partnership principles that can be readily taken up by service providers. We've often heard that one of the barriers to implementing the practical guide is issues around confidentiality and consent; we believe those issues can be overcome through the use of the guide.

And I don't think that should be a barrier to mandating the six partnership principles, or their equivalent, across commissioning environments, because we're told time and time again, "We'd love to do it, but we're just too busy." And yes, for people that don't consent to have their nearest and dearest involved, so their network of supports; that's entirely, you know, their right. But where they do, and families are still not involved in planning or decision making, then what happens when the person leaves that environment? They're usually going back to their network or support who are none the wiser about , "Well, how am I actually going to follow-up, once they leave?"

PROF KING: I'm just aware of time. And you're fine? Did you - - -

MR COGGIN: But can I just then add, you are actually highlighting - the partnership standards were actually designed - and it was a co-design model - to address the very tension around consent. And in one of the standards, there are actually guidelines about how we can gain consent for family care inclusion and respect our consumer at the same time. And since people have been using that, it's much easier to include. So think Katrina early - that other system - if we got that in there alone, could potentially start to drive that change.

MS ABRAMSON: Good, understand.

PROF KING: Thank you very much. Thank you for your participation, and I look forward to further engagement there, and your submission.

A couple of things we haven't had time to really chase-up on: you mentioned chapter 13, how that translates; if you're able to literally give us the practical examples? Say, "Look, here is what you say in chapter 13, but we don't see that in recommendation five, seven or not." That would be fantastic.

The other one that you raised - so I'll come from left field from others - we didn't go down the NDIS track, and you did mention NDIS as a way of empowering consumers for that psychosocial support, as opposed to in a sense, a less formal or less direct type of approach. If you have thoughts on that, we really would be very keen to hear them because we didn't go down that approach. If that judgement by us was wrong, we need to know about it; if it was right, we also need to know about it.

So recognising that you know, NDIS has its own issues, but be very keen to get feedback on that, so thank you very much.

MS ARMSTRONG: Thank you.

MR COGGIN: Thank you.

PROF KING: Thank you. Would you be able to state your names and organisations for the transcript?

MS WELLS: Leanne Wells, CEO of the Consumers' Health Forum of Australia.

MS GELBART: Lisa Gelbart, Senior Policy Officer from Consumers' Health Forum.

PROF KING: And do you have an opening statement?

MS WELLS: We do, thanks Stephen. Look, I guess from a CHF point of view, our interest in this, we came at our submission to the Commission's inquiry because we are concerned about multi-morbidity; that's really what the health system is managing today. And mental health, and mental ill-health are so much enmeshed into that.

We drew on a lot of insight from our members, a consumer sentiment survey we did, a specific survey around to inform our submission, and our youth health forum in sort of framing our thoughts to you. So just some introductory comments from us:

I think the expansive call to action and the range of recommendations you've canvassed really just highlights that mental ill-health is a resounding problem, and a growing problem for our system. So I suppose a "thinking differently" approach to action is long overdue, is what we would say. I suppose it all really talks to the need to refocus our systems of care.

And l say "systems" plural quite deliberately, because one of the things we think is really important is that your recommendations much equally ensure that other systems, such as primary care and aged care, are better equipped to respond to mental ill-health, and are better integrated with specialised mental health services. So I suppose because we look at the system from a very macro point of view at CHF, we've looked at a whole of system, whole of person; we've taken that whole of system, whole of person perspective.

We think primary healthcare deserves special mention and attention, because that's the setting where the great majority of people, where the biggest burden of mental ill-health, depression, anxiety, falls and is cared for; and if it isn't, it probably should be. But that primary healthcare system and strengthening of that needs to be nested in a system of step-up, step-down, higher intensity, lower intensity, service options.

We are very strongly of the belief that services are best planned, co-ordinated and integrated regionally, so we are very positive - and have been, consistently - about the role of primary health networks. And I know you've also canvassed the idea of a regional commissioning authority. I think whether it's a regional commissioning authority or an evolved primary health network, or a more empowered primary health network, can come out in further discussion. But I think the principle of regional integration, local governance, local clinical and community and consumer leadership, and pooled funding, are the ways we are going to stimulate change, ground-up.

So that really then brings us to new models of governance, and the question about what role do consumers and carers, as change-agents in their own right, play in those sorts of arrangements. We've heard earlier about the role of consumers and carers in service design and redesign; that's a really important area of investment, and an area where we think the sort of whole architecture around this has some missing links.

We know that there that the state consumer and carer alliances have formed a national alliance; so a much stronger national and independent consumer/carer voice is something we would think needs further exploration; we think that has merit. But also, just picking up on the threads of the conversation earlier about what do we do about equipping I suppose, and supporting consumer and carer advisers, to play a meaningful role in service system design and service design and development?

There are some interesting models emerging about how that could happen. Because, I think it is incumbent, your question, Stephen, it is incumbent on really local commissioners to invest in skilling-up and working with the consumer and carer community, in order to do that. One of the things that I point you to is a demonstration program - and this is just one model - that we've been rolling out with the support of four PHNs and Safer Care Victoria, and the Australian Safety and Quality Commission, is a model of joint leadership development called "collaborative pairs," where a pair - a clinician and a consumer - will do some joint leadership training together.

But that's the skills development component. The more powerful component of that collaborative pairs demonstration program is the fact that they work together as a clinician and a consumer pair, on a shared work problem; so it might be a service redesign, it might be how to strengthen governance, it might be, you know, how to get a practice more responsive to consumer and carer or patient experience data, or something like that.

A couple of final remarks; we are also signatory to the Charter 2020. I think there remain profound barriers to access to care. We hear a lot about stigma continuing to be a barrier, but one of the big-ticket things we hear about and research a lot at CHF is the whole issue of out-of-pocket costs, and the extent to which that's a barrier. We want to do some more work in that space, which we will hopefully do, in order to inform our next submission to you.

And then just a final comment on peer-workforce and workforce generally. We got very strong interest in the homework we did, I suppose, to inform our survey about the place and value of the peer workforce, and how important that is; about what sort of system of safety, quality, you know, accreditation, quality assurance, should be put in place about that, and considered. And what are the possible emergent workforces we could consider, particular in the context of the psychosocial side of the service delivery equation?

We've been watching the developments in the UK very closely, around social prescribing. And we're running a roundtable on that topic, with the RAC2P in a couple of weeks, and the

NH and MRC partnerships in system sustainability, where we want to look at what a social prescribing scheme could look like for Australia. And one of the models, one of the workforce models they have in the UK, is the notion of link-worker attached to a mental health service, attached to a headspace, attached to a multidisciplinary general practice-led healthcare home, that can really provide a referral pathway to assist people into navigating and accessing some of those non-clinical services that are so much a part of managing their mental ill-health and coping with it, but also recovery.

So I might leave it there.

PROF KING: Can I pick up just that last point? Because it is one obviously that's really interesting us. If we make it much clearer across the spectrum, about the psychosocial supports and the clinical supports needed working hand-in-hand; the social prescribing is clearly one model to try and do that.

And apologies, because obviously it's ongoing work that you're doing, but do you have any thoughts at the moment of how that would work in with the Australian physical health system, which is very much built around small GP practices? And for most people with mild mental health, or when they're first diagnosed, it's often the gateway that they go through.

But it's difficult to think how a social prescribing model fits in with that, because it starts to become - you've got an awful lot of very small practices, you know, from single GPs to up to five or six. But how do you build social prescribing in that model?

MS WELLS: I don't think there is a one-size-fits-all model; I think that would be the first thing I would say. You know, we've got a 10-year primary healthcare plan - if we're talking the primary health care system - in development. One of the ways to build it in is to build it in systemically, into primary healthcare arrangements. So that could be a combination of - and this means investment, and it needs to be systematic - but it could be arrangements whereby link workers and localised social prescribing menus - by that I mean building into health pathways all GP practices now have access to, mostly, on their desktops, built by primary health networks.

So health pathways; take, you know, disease issue by issue, take GPs through diagnosis, management, referral option pathway. So the question is to what extent do they have community services and community service referral options built into that? So that just makes it easy from a GP point of view.

But the other piece of research that we've just done - and I'd refer you to this - is, we surveyed over 1700 people, because our interest is multi-morbidity; so over 1700 people, I think it was almost 1800 people, with two or more chronic conditions, including mental health. And what we found there was using a validated measure of patient activation, surprisingly - or not - people with lots and lots of comorbidity were really low on their activation scale, which is sort of counter-intuitive, because they're unwell, they got mental health comorbidity, you'd think that they would be quite activated to get well, or get better, or better self-manage.

So to answer your question, I think we need systematic use of patient activation measures; we need systems like community referral and psychosocial referral pathways built into systems that clinicians already use, to make it easy; and we, ideally, would have, as they do in the UK - and not all roads lead to UK models, there are others - but a network of link workers that can be part of a multi-disciplinary wraparound team, to assist navigate some of those social and psychosocial services, and indeed, referral to other health services as well.

So that workforce could be attached to a practice and paid for by a practice through potential reforms that could happen under patient-centred healthcare home future models of care, or like we've seen with general practice based pharmacists, they could be a workforce or a capability engaged, employed, contracted, by PHN who would provide that sort of workforce support, through outreach models, to clusters of practices. Because your point about general practices being small businesses is a real issue, yes.

I don't know whether that's answered your question.

PROF KING: I think so, that's really good. But I won't follow-up on that, because I will not hog the conversation. Julie - - -

MS ABRAMSON: I only had one thing I just wanted to ask about. And I apologise if I'm misquoting you, Ms Wells, but I think you said something about consumers and carers as change agents, and I'm really interested in understanding what you encompass in that.

MS WELLS: Well, I think I'm just really referring to the evidence and the experience in the system, that if we've got data about patient experience, and if we've got information about patient outcomes and what actors contributed them to arriving to a better outcome in a particular circumstance, that's important information. And it's a really simple question, encouraging clinicians or commissioners to flip the question and start asking, you know, rather than what's the matter with you, what matters to you?

Because often, if you're asking someone - and particularly someone with mental ill-health - you know, "What matters to you? What's going to make a difference in your life in the way you cope with your mental ill-health problem and in your recovery?" then yes, medication and a good medication regime and those sorts of things are obviously factors. But often, it'll be the things like, "I'd like some support to overcome some social isolation. I'd like to have my pet returned." I mean, it's those sorts of really practical things as well.

But I think the whole point about consumers as change agents is really insights from patients can better determine how we shape services, so that they're more responsive, yes.

MS GELBART: So we use a local of clinical outcome measures at the moment, but not so much sort of primary. Sometimes, patient outcomes and patient experience measures might change the way we think about changing our services, or even the broader system. And so yes, I think we're talking about patients acting as change agents, consumers acting as change agents, at all levels of the system, so from the very ground level. This was my experience, and so we need to think about the way we deliver that service differently, to the bigger structural - - -

MS ABRAMSON: No, I understood, because behind all of that is the cultural change that you're talking about.

MS GELBART: Yes.

MS ABRAMSON: Yes, I understand, thank you.

MS GELBART: Yes.

PROF KING: Harvey?

PROF WHITEFORD: Leanne?

MS WELLS: Yes, Harvey?

PROF WHITEFORD: So I guess jumping to the issue of the regional commissioning authority and the role of PHN in that primary care.

MS WELLS: Yes.

MS WELLS: Yes.

PROF WHITEFORD: So we spent a lot of time trying to mainstream mental health into health.

MS WELLS: Yes.

PROF WHITEFORD: And we've been successful. The downside of that appears to have been the criticism that it's now fragmented across primary care, specialist care, hospitals, community, so one of the proposals in the report is original commission authorities,. 'Will we pool the funding, all the community funding, into a pool?' and we look at planning at original level.

MS WELLS: Yes.

PROF WHITEFORD: The criticism of that is that you're creating a silo here for mental health in the community and it will have a downside but it will be separating from physical health and how it would deal with, you know, what happens in the beds in the hospitals so we're trying to get that balance right, I think, in the report where we build a strength of that for integration but we are aware of not wanting to create, you know, a middle health silo in the community, that's separate from health. Multimorbidity, the issue you raised, is clearly a classic example of why that would be bad - it would be bad for other reasons as well. And I notice you've commented about that. Could you just give us some initial reaction to that proposal and how you could see getting that balance right?

MS WELLS: Well, I thin - I mean, I do think it comes, from where we sit and we're not representing and coming from the, you know, consumers with a really acute mental health issue. There'd be other organisations that would speak with much more authority on that issue but on the multimorbidity issue and the fact that, you know, people in that cohort need specialist mental health services, they need good physical health care and good psychosocial support then it comes back to we do want an integrated system.

PROF WHITEFORD: Yes.

MS WELLS: And I think it, you know - New South Wales health, for example have invested in some degraded care models and invested pretty seriously in, what do they call it, alliance commissioning, you know, they do that in New Zealand where they - where the different funders do come together locally or regionally and, you know, commission together - agree outcomes and accountable outcomes together of services. I just think we've got to take that plunge. From what I can see around the country New South Wales seem to be leading it in terms of integrated care for, you know, in areas other than mental health but, you know, I think we've just got to take that plunge and look at some sort of co-commissioner and alliance commissioning at a different scale to that we currently we have because I know, you know, some PHNs, some LHDs are, you know, making some pool raising to that area.

I know that - I think it's the New South Wales - well, the New South Wales PHNs have pooled money but that's the PHN's pooling money, it's not the LHD's pooling money but that whole pooled - the sense of pooling in regionalised planning to solve a problem, to solve a structure problem, I think is the way to go so they've pooled money to provide a sort of a consultation liaison psychiatry advisory service to general practice because it was difficult to do it at scale on: (1), doing it but there were economies and efficiencies for all sorts of reasons, workforce availability, you know, so I just think that whether it's PHNs or whether it's a new construct is the question I think.

PROF WHITEFORD: Yes.

MS WELLS: And, you know, we saw a lot of disruption - I'm probably shifting hats now from when I used to work in that sector but we did see a lot of disruption in the transition from Medicare locals and a lot of cost to PHNs. Whether that should be disrupted and rebuilt or whether PHNs should involve and as part of both your work and the work of the ten year primary healthcare plan taskforce should be looking, you know, at what systemic role should PHNs or PHNs mark two have in the system I think is the question.

PROF WHITEFORD: So, sorry, just following up. So the integration is the continuing of mental health care and the integration is with physical care primary care at the same time because they're both critical to the outcome for the consumer.

MS WELLS: Yes, and I think - I mean, I always have in mind that nice graph in the National Mental Healthcare Commission contributing lives report where - it's also about integration across, you know, physical care services, acute, you know, aged care too for that matter but it's also about, you know, where the investment is most concentrated and that graph where we - yes, we're skewing the investment back to early intervention, recovery at the other end but a much more robust investment in, you know, wrap around comprehensive multidisciplinary community based service solution.

PROF WHITEFORD: Yes.

PROF KING: Can I follow up on a slightly different but it really comes back to consumer empanelment in the system and there's issues we've - as you've said you want to avoid silos, you want to avoid the issues of lack of connection but when somebody says there's a lack of connection at the moment across lots of parts of the health system, and I think I'm taking you back to your (indistinct words) in mental health, obviously across the whole health system. In some areas, as you've be aware from (Indistinct), we've tried to address that by data by saying - well, in the sense of powering consumers by the consumers having more control over their medical data, their medical records, their - if there's a coordination, care coordination plan, you know, really saying consumers and carers need to - the data's really about them, it's for them, they should then be able to use that and control that and it seems to be something that the Productivity Commissioner has recommended elsewhere and it's been brought in the banking and essentially brought in utilities but it seems almost a foreign idea in health where there's been attempts through the My Health Record which I won't go into. Do you think in a sense we need to think about that path, perhaps using again mental health as the broader of health reform but it's that consumer data right in the mental health or in the healthcare system?

MS WELLS: Well, I think - I mean, consumer data and, you know, Tim Kelsey talks about, you know, the noting of the health in your hand, you know, how important our devices are these days for nudging us to better self-manage so I think, you know, we've really got to look at data and how it's used. If we look at data and how it's used both systemically but also how it's used and fed into devices and digital platforms to nudge and prompt consumers to act or better self-manage or respond and often that's hard, you know, for people with very complex mental ill health, I wouldn't want to speak on their behalf, but I imagine there are, you know, times in their lives where that's going to be difficult. Do you want to comment on that, Lisa?

MS GELBART: Yes, I mean, I think if we look at some of the technological capability that exists around apps, remote monitoring, different models of care that allow people to, you know, stay in the community, self-manage, be at home with their supports when they might otherwise not, that model of care kind of already creates a shared data system so it's maybe not about the consumer entirely owning all of the data but it is a shared data between the consumer and the clinicians and carers as well and has the capability that, Your Honour, creates a kind of network of community people that all have access to this simultaneous so I think there's huge opportunity there but we don't quite have the infrastructure to facilitate it yet but, you know, people are doing it outside of our structured systems already, people are downloading apps onto their phones and using them to self-manage which is not weaving it into our, you know, public health systems.

PROF KING: You actually just described PC's consumer data right, it's not about ownership, it's about co-ownership and co-rights over data.

MS GELBART: Yes, absolutely, and I think most consumers would completely accept it, so.

MS WELLS: Yes, and we did get a lot of feedback just on the My Health Record issue, you know, people with HIV aids, people with mental health conditions concerned about employers finding out - you know, that whole, you know, debate that exploded I suppose when My Health Record - you pre-opt out, you know, when that whole debate was happening

- you know, elements of the legislation ended up getting strengthened. I suppose we kept trying to bring it back to - well, My Health Record is a personally controlled health record. It's not your full set of clinical notes. If anything, people with complex mental health conditions, multi-morbidity, are the greatest beneficiary of this.

The issue is utility, doctors using it, Allied Health using it, you know, connectivity and the social licence around public confidence and trust and, you know, I think the more it embeds and the most it gets used, you know, the more it will become part of our health service landscape because, you know, from a safety and quality point of view different clinicians involved in different aspects of someone's care just being able to see what sort of meds people are on and the range of meds they're on with consent are so important, You know, so many misadventures and missteps and people having to bounce backwards and forwards between clinicians because some of that basic stuff around a care plan is not immediately evident or shared.

MS GELBART: But I think having the consumer involved in the design of the system from the beginning helps to avoid that kind of - some of the privacy and security concerns at the end. It's the, 'Oh we didn't know that that wasn't going to be included' and that's where (indistinct words).

MS WELLS: Yes.

PROF KING: Thank you very much.

MS GELBART: Thank you.

MS WELLS: Thank you.

PROF KING: Can I suggest we break. I'm aware we have a lot of people today so can I suggest we break for about 20 minutes for morning tea and we'll look at resuming at about - what are we, we're come - about 10.40.

SHORT ADJOURNMENT

PROF KING: Okay so let's get restarted. I think we're hearing from Early Childhood Australia next?

UNIDENTIFIED SPEAKER: (Indistinct words).

PROF KING: Yes, please.

MS ABRAMSON: And I'm sorry if we're shouting but apparently people at the end of the phone can't hear us, so.

PROF KING: Actually just before we restart let me just reiterate a few things for people who didn't hear this morning. The microphones are just for the transcript. They're not for amplification. If any media have come in please identify yourself to our staff and given the nature of the proceedings can you please make sure as members of the media you're respectful in your approach. As I said this morning also we know some of you are going to talk from personal experience. please be aware this is public, there will be a public transcript and so please be aware of privacies, protections and refrain from naming specific individuals. We wouldn't want any proceedings out of this that would be undesirable for everyone.

MS ABRAMSON: Yes, Stephen doesn't want me to use my dormant legal skills.

PROF KING: Yes, I think - and mobile phones on silent. All right, let's start again. So if you could name your organisation for the transcript please.

MS PAGE: Sure, thank you. So I'm Samantha Page, CEO of Early Childhood Australia and thank you for inviting me to be here today and to talk to the draft report. By way of background, Early Childhood Australia is the national peak body representing the rights and interests of young children from birth to the age of eight, which encompasses early childhood education and the early years of school. Our membership is national and includes both organisations and individuals that work with young children are involved in the delivery of early education, including preschool, kindergarten, long day care, family day care, outside school hours as well as RTOs and universities that are involved in preparing teachers and early childhood educators through qualification training.

ECA did make a submission to the inquiry and we had welcomed the Productivity Commission's draft report, particularly the call for funding to support early childhood educators and teachers to receive evidence-based training in social and emotional development and identifying young children who are at risk or who are showing early signs of difficulty in social and emotional development.

We play a leading role in supporting young children's mental health directly through our participation in Be You. We are a delivery partner in Be You, which is the national education initiative, along with our partners Beyond Blue and Headspace. We currently have 2,891 early childhood services engaged in the Be You professional learning and 18,000 individuals, which roughly represents about 20 per cent of the early childhood sector engaged in that initiative.

I don't think it's possible to overstate the importance of social and emotional development in the early years. This is when the foundations for future mental health are established. It's when children develop their sense of identity, confidence, recognise their emotions and begin to learn to regulate their behaviour. We have a saying: the first five years last a lifetime, and that's particularly true for social and emotional wellbeing.

In our initial submission to the inquiry, we laid out the evidence around developmental vulnerability and disruptions in the developmental process and how that can negatively impact on children's capacity for learning, understanding and expressing emotions and relating to others. We understand the presence of protective factors that can decrease the likelihood of mental health difficulties emerging and how important it is that young children have really high-quality services provided to them in those early years.

Early childhood education care services have the potential to provide those protective factors, both directly in how they work with young children, and we have over a million children in early childhood services in Australia, but also how they engage with families. There's a very close relationship between early childhood educators and families. Parents are generally bringing children into the centre, children up from the centre and communicating with educators on a day to day basis. So the capacity to support families and influence the home environment as well as the environment in the early childhood education sector is quite significant.

We know that the early childhood sector is very willing to engage in professional learning. We can see the enthusiastic uptake in Be You, which was only launched last year, so to have over - nearly 3,000 services and over 18,000 individuals engaged shows a level of enthusiasm and appetite for professional learning in this area.

However, the cost can be prohibitive, particularly for small stand-alone services which is the majority of the long day care sector. They are small businesses or small not-for-profit organisations. Releasing individuals and the whole of the team for professional learning can be quite costly.

So we are particularly welcoming of the Commission's draft recommendations around resourcing early childhood services to release professional for professional learning engagement and that makes it more possible to raise the skill level across the whole team within the service rather than just one or two individuals participating in professional learning.

We also think it's worth considering having more intentional directive around social and emotional development in the national quality standard for early childhood education and care and potentially through the teaching standards as well.

ECA is particularly keen to support outside school hours to be involved in this area. These areas are providing support before school, after school and during the school holidays. They're very well placed to support social and emotional wellbeing, learning and development. They're not as crowded in terms of curriculum as perhaps school settings are, and they already have a strong focus on wellbeing. These are settings where children are encouraged to play, to engage in recreational activities, to be physically active and to foster friendships with other children. It's a really ripe service setting for the delivery of more programs that build children's skills and capacity and social and emotional wellbeing, and there's an enormous potential to upskill educators working in that sector to proactively teach children around things such as managing emotions, how to response to feelings of anxiety or negative experiences such as bullying.

ECA also strongly supports work to increase parents' understanding of early childhood development, including factors that promote good mental health increase children's resilience and reduce risk over the long term of issues such as anxiety and depression emerging. Educators in early childhood services do already work within this context of complexity and have that connection to families, but they often don't have the capacity to develop more than provide the service during the hours that the subsidy is funding the service to be provided. So there's the capacity to add greater resources to services to engage with families, and we've seen a lot of those models working very well internationally.

Lastly, we're supportive of the recommendations in the draft report around coordinated approaches to enhancing the capacity of the mental health sector to work with young children and provide early intervention when difficulties first arise. Adult models of individual therapy and group programs often don't translate into early childhood settings or work for young children or children in the middle years.

Early childhood services would like better access to infant mental health specialists and experts in trauma informed practise and behaviour modification advice when they identify children who are experiencing difficulties. The system currently tends to provide very broad-brush prevention and I would include Be You in that in terms of raising awareness of what is social and emotional development and building capacity around that, and then it provides crisis for responses, but we don't have a lot in the middle, and so where early childhood educators would like more support is to be able to access experts and specialists at the time that they need it, when they are identifying a child with difficulties and be able to tap into that.

It's often not about introducing another adult into the child's life. It's not about the child seeing the specialist directly. It's about the specialist providing advice to the parents and the educators and the teachers that are already working with that child. So it's really about having - and we don't have good models for that, and we don't have good models under Medicare for that. You can't bill for a consultation with a teacher or an educator or even with a parent on behalf of the child if the specialist doesn't actually see the child.

Same complexities arise in the NDIS and other systems where we have built funding systems based on a direct relationship between the practitioner and the patient, if you like, or the participant, rather than third party support to parents or to educators and teachers in school settings who are supporting the child and who already have a relationship with the child, so a better place to implement some of the interventions that might be appropriate.

So we use the example of changes in the way speech therapy is delivered as an example. It used to be that children would be taken out of the setting, taken to the speech therapist and worked with one on one by a speech therapist. These days we have much better models where speech therapists come into settings, observe the child, develop a program that the educators and parents can deliver and the child stays in the early childhood setting and receives that extra support through the adults that are already in that child's life, and those are more effective. It means the child is getting many more hours of intervention, if you like, than if they're taken away and supported one on one. So I think we should be looking for similar models in the mental health area.

Do you want me to respond specifically to the recommendations or is it better to answer questions?

PROF KING: I think actually why don't we go to questions and – - -

MS PAGE: Sure.

MS ABRAMSON: Ms Page, thank you very much, and thanks for your engagement with the Commission. One of the things that we were very clear about which you picked up on is support for the early childhood sector for professional development and professional training. One of the comments that was made publicly about this is an issue of additional cost, and it wasn't made by your organisation, but we would be interested in comments on that because what we really had in mind was support in the training of early childhood educators and also a government - I think I've got this right - government support when people needed to go to in-service training, so quite interested if you do have a view on that.

MS PAGE: Yes, certainly. I mean, so we see Be You as a comprehensive package of professional learning.

MS ABRAMSON: Yes.

MS PAGE: And there is enthusiastic take-up of it, but the barrier tends to be the cost of releasing staff to go to it.

MS ABRAMSON: Yes.

MS PAGE: Certainly we don't want - there's also an issue with people feeling pressure to do it in their own time rather than to do it as part of their paid work.

MS ABRAMSON: Yes.

MS PAGE: And also to do it - we would rather whole teams engage in that learning rather than just individuals upskill on their own but that's not reflected in the way the whole service operates. So there is a cost factor in terms of releasing people. One of the difficulties in early childhood is that, while we do have qualified teachers and we have about approximately half of the educators are diploma qualified, half the educators are certificate qualified, Certificate III, there's not a lot of room to move in the Certificate III; not a lot of time to spend on social and emotional development.

So while there is a consortium, Emerging Minds, Australian Institute of Family Services, that have been funded to develop content for inclusion in pre-qualification courses, including the certificate and the diploma and the teaching degree, the difficulty is how much can you cover in a short limited course such as the certificate. Some people would be offending at me calling that a short course, but there's a lot of competing priorities in that pre-qualification space.

MS ABRAMSON: We're very well aware of training system in Certificate IIIs, but if there's practical things that you'd like to say in your submission about that and how those things can be incorporated, because we've already said, 'Look, this is really important,' but if there are pressures because a Certificate III is a shorter duration course than a diploma course, we'd be really interested in hearing from you on that.

MS PAGE: Yes, and there's still a lot of room to enhance the training that's provided in the diploma qualification and in the teaching degree, particularly if we can move back to teaching degrees that focus on the early years, so birth to five or birth to eight. There's a lot more scope then to really upskill around social and emotional wellbeing.

Of course, one of the difficulties is the early childhood workforce is 200,000 people strong, and that doesn't include the teachers in schools.

MS ABRAMSON: Yes.

MS PAGE: That's just the teachers and educators in early childhood settings. So to make a difference to that workforce takes a very long time. Professional learning that needs to be provided is of a significant scale to make a change to practice. Now, we can do it, and there are models such as the long day care professional development money under the Abbott government that funded backfill and funded the cost of early childhood educators to be released or training, and so that model there is a precedent for that kind of model and we know we can get a high number of people through training with that kind of support. But that is what it takes, and it is quite a large scale, and I think that the urgency of the mental health issues we've seen, particularly in adolescence at the moment, warrants it.

You know, if we're going to make a dent on suicide rates, if we're going to reduce the frequency of anxiety and depression occurring in adolescents, we need to start now with the cohort of children in early childhood setting.

PROF WHITEFORD: So what are the recommendations about the three-year-old health check? I don't know if you saw that. And trying to graft onto that a psychosocial health check, that there is a Medicare rebate for primary care positions to do. Did you have a view about that, or a comment about that at all?

MS PAGE: We certainly support the intent. I think it's quite a costly exercise, I imagine. I mean, I'm not an expert on the cost of that sort of delivery model through GPs, I'm assuming. I imagine it's quite costly.

Our issue was that we really need to be explaining to parent what it is that's being tested and why, and also that often the adults in the life of - the adults in a child's life know there's an issue. What they don't know is what to do or where to go or how to get help for it. So educators - if the child is participating in an early childhood service, chances are the educators already know that that level of anxiety in a child of that age is unusual or that the separation anxiety that might be normal for a child when they first come into a setting has gone on for too long, or that there are other signals that that child is not coping. The difficulty is where to go, and they probably wouldn't automatically think of a GP or think of suggesting to the parent that they raise it with a GP, and that might be an issue of not really knowing what GPs are going to do with that sort of information or where parents can go for help.

PROF WHITEFORD: Just one follow-up question: do you have, or can you provide us with, any examples of early childhood services where there are good links with I guess mental health expertise that's required and has proven to be of value to that service to the children who are there and their families?

MS PAGE: There's some very good integrated models working with highly vulnerable populations of children where they have as part of the service team infant mental health specialists and family support workers and people with qualifications in psychology and social work, and they are demonstrating - there's one in particular, Kids First in Victoria, that is a randomised control trial and being intensively researched. I think they're on their fourth data release at the moment.

Now, they're demonstrating very significant improvements, particularly in social and emotional wellbeing, for young children, but they're working with a very vulnerable cohort where there has been trauma and children are in high risk. So, yes, there's certainly evidence for those very vulnerable populations that a holistic wrap-around service like that where those experts are imbedded in the delivery of the service. It is effective. That's not necessarily scalable across the whole early childhood sector, but certainly if early childhood educators and teachers had access to people with those skillsets on a more case by case basis, I would imagine that we would see an improvement there.

And certainly in international models of more intensive support where support is provided in a home as well as in a service setting, we know that that's very effective.

PROF WHITEFORD: Thank you.

PROF KING: Can I follow up on really that last point, because one of the things we were very conscious of in our draft report is having effective gateways to services so not wanting to duplicate community services in, say, schools, but rather making sure that schools are effective gateways out to community services, and similarly I think the early childhood sector.

Early this morning, we had some discussion around families, and you've again mentioned the role of families and the importance of families and for vulnerable cohorts providing, you know, the wrap-around services as you said. Have you thoughts on how we, in a sense, fit that together? How do we make families an effective gateway into these services? So, you know, you can have a trial where you say, 'Okay, these are vulnerable groups,' for support, but how, for the population as a whole, can we make it easier for families as well as the early childhood sector to find the care that the children need?

MS PAGE: Yes. I've worked across family support, family law, child protection, social services and now early education.

PROF KING: Yes.

MS PAGE: And I don't think there is one model that works. I think what we need is to empower local communities to decide what is the mix of organisations and services that they need and how they want to organise those. So sometimes the local school is absolutely the place that is the hub of the community, and you could locate your health professionals, your mental health professionals, your family support workers, around the school and they could reach out to early childhood services and preschools and kindergartens and long day care services in the area, and that would be absolutely appropriate.

In the next community down the road that would not be appropriate, right? I think that in the next community down the road it might be that the neighbourhood house or the local Aboriginal organisation or a group of preschool and kindergarten teachers are the safe places for families or the soft entry points for families, and we would be better building their capacity to be that front entry point that you're talking about.

In other places, you need a mix. You need people in different locations because you've got different population groups that are going to seek help from different service providers, and I know that's not very helpful to you and you're trying to make national-level recommendations, but I do think some kind of cascading approach.

There are some things that are really efficiently done at the national level. So one of the organisations that I'm involved in is PANDA, the Perinatal Anxiety and Depression Association. Now, their social media campaign at the moment - I don't know if you've seen it, but their social media campaign about normalising feelings of anxiety and depression in that early stage of having a baby and seeking help for that is really good, and that makes sense to do that nationally, because that doesn't differ from one community to the next.

But at the local level in terms of where a new parent might go for help, we need to have a range of options. Some people won't feel safe going to the school, some people won't want to go to maternal child health, some will want to go to their local community organisation or their local Aboriginal health centre. Sometimes there are preschools and kindergartens that are really good at reaching out into the community, having playgroups running on site, bringing families in at a really early point, and some degree of local flexibility I think is important.

The other thing I would mention is that the research is in, well and truly, on integrated early childhood settings, so where we can provide an early childhood setting that does offer long day care or does offer preschool, does also have a playgroup, does also have a visiting nurse who can weigh babies or do ear and throat checks and can do vaccinations, where we have an infant mental health specialist as part of that integrated setting, it works. It's very effective. It's an efficient way of delivering services and they can create a very safe and welcoming environment for families.

The difficulty is they're expensive to run, but more than anything, it's impossible to navigate the array of funding mechanisms that you need to be able to fund all those different functions, right? So you need to be an approved provider under the Child Care Subsidy to deliver long day care, but you need to work to social services to have access to playgroup funding. You need to have your infant mental health person funded under the National Mental Health Strategy or through the National Department of Health. You need something else funded from the local health networks.

For services to do it, they're having to manage - I spoke to one service that's got like 30 different funding agreements, and they're all on different time cycles. Do you know what I mean? So how do you manage your basis outgoings like rent and infrastructure and other things when you don't know whether that position is going to continue beyond the current funding cycle, and that one's coming to an end at the end of the year and the other one - I think we need a funding model for integrated service delivery. We need a lead national - whether it's the Department of finance or - I think it would be the Department of Finance - to say, 'How can we encourage pooling of funds from different - from education, health and social services in order to fund integrated service delivery on a longer cycle and not rely on individual organisations being so motivated to do it that they're willing to navigate all of those different regulatory frameworks and funding models?'

MS ABRAMSON: Ms Page, it would really helpful if in your - I'm sure you're going to do a follow-up submission - if you could sketch some of that out for us and show us, 'Look -' I mean it's really interesting evidence that you've given us. There are all these different programs, because we were very sympathetic, at least in the psychosocial support area that people needed longer contracts because a year contract was really not very helpful, so we're very interested in that.

MS PAGE: Yes. There's some really good work that's been done in that space. Absolutely.

PROF WHITEFORD: One more question before we let Samantha go. One of the things that happened when our draft report got released was the push-back around identifying what we might have called, you know, early intervention for mental health problems in young children, preschool children.

MS PAGE: Yes.

PROF KING: You don't mean a certain headline?

PROF WHITEFORD: Well, a certain headline in an unnamed paper.

MS PAGE: Yes.

PROF WHITEFORD: But it was this - and this has happened to us once before where it was, you know, 'You can't possibly be thinking about mental illness in young children. This is all about driven by pharmaceutical companies who want to put people on -' whatever. But it seemed like the stigma that we've fought hard to reduce in adults, whether that still exists in children, that they can't have a mental health problem, or they can't be on a trajectory to a mental health problem, and it might be about language. It's about helping the family, it's about psychosocial and emotional wellbeing; it's those sorts of things.

Any feedback, any reflections on that sort of issue around this stigma of those sorts of conditions in, say, the very young children, up to five?

MS PAGE: Yes. I mean, we've had similar accusations from our role in Kids Matter and now in Be You that we're pushing for diagnosis of mental illness in young children and that's absolutely not true. We don't look for diagnosis in children under eight. It's why we use the language of social and emotional wellbeing and social and emotional health and social and emotional development rather than mental health, and certainly we're not in the business of medicalising, you know, issues that children are experiencing in the early years.

By far, the better responses are generally in equipping the adults, whether that's the educators and teachers in the early childhood setting or the parents at home or the broader family, to identify and respond appropriately to the emotional difficulties that a child might be experiencing. I think we just have to keep putting that message out there and, yes, certainly we're arguing that in the early years it's about laying the foundations for good mental health, as it is in physical health, as it is in every other area, we are preparing children for a lifetime of educational engagement and confidence and wellbeing and relationships.

The area of difficulty that we've had in talking about - we've got some really good professional learning for educators around supporting children to have respectful relationships with each other, which is long term prevention of family violence, but also bullying and toxic adolescent relationships, if we can start with children in very early years and teach them how important it is to be respectful to each other and what that looks like, and we can have everyone around them modelling respectful relationships and dealing with conflict in an appropriate and healthy way rather than an inappropriate way, we can make a real difference.

But that's not to suggest that children are to be stopped from being children or stopped from having normal emotions or that their two-year-old behaviour is not respectful or not normative. It's really just about establishing that very early grounding in what does it mean to be respectful to other people.

PROF WHITEFORD: Right. Thank you, Samantha.

MS PAGE: Thank you, and I will send some links and make sure they're in our submission.

PROF KING: Thank you. We have people heading out. Yvonne. The chair is a bit uncomfortable.

DR LUXFORD: It's okay, thank you.

PROF KING: Thanks, Yvonne. Would you be able to state your name and organisation for the record, and then if you'd like to give an opening presentation?

DR LUXFORD: Thank you. Thank you, Stephen. It's Yvonne Luxford from Perinatal Wellbeing Centre. I acknowledge the country that we're meeting on today. I acknowledge elders past, present and emerging and thank the Nanamula and Numburi. People for caring for this country so well over time, and thank you also for the opportunity to speak today. We really appreciate the chance to share some ideas with you.

As a bit of background, Perinatal Wellbeing Centre is an accredited mental health service which specialises in the care of parents experiencing mental health issues from pregnancy through to when their child reaches the age of 2. We individually assess each client and we develop a tailored plan of support to best meet their needs, including ongoing telephone counselling, workshops and group sessions which focus on developing tools and strategies to best manage their problems.

We are grateful that the Commission's draft report shines a light on perinatal mental health and the long-term ramifications for both parents and children if these conditions aren't recognised and treated.

On that point, we would like to see a significant broadening of the recommendations from the current focus on universal screening, but more on that in a moment.

Perinatal Wellbeing Centre has joined with three other key perinatal mental health providers - Gidget Foundation, Peach Tree and PANDA - to form the Perinatal Mental Health Consortium, and we've commissioned PWC to research the costs of perinatal mental health issues to the Australia economy. The report was released last week, and I just note that this week is actually National Perinatal Mental Health Week, and found that one in five mothers and one in 10 fathers and partners experience perinatal depression and anxiety, or PNDA.

For each annual cohort of births, this costs $877 million in the first year of those babies' lives, and $7.3 billion in total costs attributed to perinatal depression and anxiety over the child's lifetime.

A number of cohorts including Aboriginal and Torres Strait Islander, culturally and linguistically diverse and LGBTQI communities are more vulnerable to PNDA. The communities are also considered less likely to seek help due to barriers to access, which may include proximity to services, language barriers and perceived social isolation.

The risk of experiencing PNDA is higher for those who have a previous history of mental illness. Similarly, the risk of recurrent PNDA is relatively high, particularly when the PNDA is experienced towards the severe end of the spectrum.

A study has found that women who are hospitalised for the first episode of PNDA are 46 times more likely to experience PNDA after a subsequent birth. Prevention, early intervention and tailored treatment and support pathways are essential mechanisms to assist in the reduction of society's financial burden and to foster improvement in the mental health and wellbeing of our families.

We recommend, in an environment of increasing demand, it remains crucial that the investment priorities in a broad range of services, support and treatment options to be made available to families. Service requirements are varied, ranging from individual clinical care through to group support options and must be offered in a variety of modalities, including face to face and telehealth.

Services and treatment options should be supported by effective screening program, which has been informed by consumer engagement. Programs and services should include a focus on supporting vulnerable cohorts, such as Aboriginal and Torres Strait Islander, culturally and linguistically diverse and LGBTQI communities, and efforts should be made in helping to identify cases of PNDA and provide culturally appropriate treatments in culturally safe environments.

Ongoing research should include all aspects of perinatal mental health including the prevalence and impact of paternal PNDA and the needs of more vulnerable communities. Opportunities for prevention should be explored, including comprehensive antenatalprograms focusing on wellbeing and a sustained awareness-raising program should be funded using social and traditional media to increase understanding of perinatal mental health at a population level and to increase the number of people seeking help and therefore improving family wellbeing overall.

Media campaigns need to reflect the diversity of the community and short videos in different languages should be produced for social media campaigns targeting those lacking skills in English. Thank you.

PROF KING: Thank you very much, Dr Luxford. Would you like to lead off, Julie?

MS ABRAMSON: Yes. Thanks very much, Stephen.

PROF KING: I should have warned you, by the way, or rotated – - -

MS ABRAMSON: No, I was ready to go. Yvonne, I'm really interested in your commentary around proactive identification and prevention, with a particular emphasis - because you did talk about this on rural and regional Australia, because we have struggled through this report to try and work out, especially in the early childhood space, how we can deliver some of those services. So what would you recommend in the space and how would we deliver the services?

DR LUXFORD: In terms of prevention?

MS ABRAMSON: Yes, prevention and early identification.

DR LUXFORD: Yes. I think a good antenatal program that focuses on wellbeing that could be delivered across the country in different ways I think is essential. At the moment, most parents will attend an antenatal program during pregnancy, and they tend to focus on the birth itself, on the physical aspects and also on infant feeding. Sleep and settling; you get a little bit of that.

MS ABRAMSON: Yes.

DR LUXFORD: But there's not really a focus at all on wellbeing, so I think this is something that's essential to either imbed into current antenatal programs. That may not be the way to go. That may not be what people want to hear when they're attending an antenatal program in the hospital setting, et cetera, which is where a lot of people attend a program. It may be that a mental health organisation such as our own would be delivering a program like that. It depends on the nature of it.

But also that broad awareness raising through social media and traditional media campaigns is really important, to raise awareness so that people know, even during pregnancy, that they can identify, 'This isn't right. It's not just, you know, baby hormones, baby brain type of thing. There's actually something going wrong here and you need to address that.' So that would be one side.

The screening; I mean, we do agree with the universal screening, but there's not much point in screening people if you don't have services and pathways to treatment and support as well, and any screening program that we do introduce, it's absolutely vital that there's consumer engagement in its development. We want to ensure that it's a really strong evidence-based screening program.

Currently, as you know, most services use the EPDS, the Edinburgh Postnatal Depression Scale, and the DAS as well. They're free programs. I think that's really important as well. If you want - we would love to see that every time a new parent has their first meeting, and subsequent meetings too would be great, but at least their first meeting with a clinician of any kind, that they would be screened. That would be great. And in which case a free easily available brand-agnostic type of screening tool would be excellent.

MS ABRAMSON: Can I just have a follow-up? So is the emphasis in the hospital setting? Because people are in the hospital setting, it has that kind of clinical overlay of the delivery of the baby as opposed to a broader conversation. Is that part of - it's just the way things are done?

DR LUXFORD: I think so. I think that's probably the basis of it, yes.

MS ABRAMSON: We did hear, and I'm sort of interested in innovative ideas in this space. I'm sure this is right. When we were in South Australia, they had quite an innovative program of sending text messages to new dads saying basically, 'Are you okay?' and then they had a link through to services. So really interested in your follow-up submission, which I'm taking that you will give us, right?

DR LUXFORD: Yes.

MS ABRAMSON: As some of those kinds of innovative things and particularly you talked about levels of government and that it makes sense for some programs to be delivered at the national level, so really interested in any thoughts you have in that space.

DR LUXFORD: SMS4dads was a program out of Newcastle, I believe, originally. I think it was defunded unfortunately. It was a fantastic pilot program which was very successful, but unfortunately the funding didn't continue.

MS ABRAMSON: In your submission just point us in the direction.

DR LUXFORD: I'll advocate for it.

PROF KING: Many things seem to start and then get defunded and disappear and then – yes.

DR LUXFORD: I know.

PROF KING: Harvey, did you want to – - -

PROF WHITEFORD: No, no, I'm good.

PROF KING: Okay. So can I then follow up just on the antenatal care. As we heard this morning, a key element really of optimal service design is co-design with consumers, and in this case with families with new parents, or parents-to-be, and I can see the issue of existing antenatal programs in hospitals and then adding the perinatal wellbeing program onto those and that it may be desirable to have separate from a perception point of view if nothing else, except at the same time I think, well, in terms of cost and in terms of participation that it's much easier to add a bit to a current program that is very well attended rather than saying, 'Well, here's one program, but there's another program over here we'd also like you to attend in a different setting,' and most expecting parents are of course time-poor and they're trying to juggle things and often trying to build up a bit of savings before maternity and paternity leave and so on. So do you know if anyone has done work in looking at the alternatives there? Do you have any views on the alternatives there? Because obviously it would be good if we have the evidence to be able to make firm recommendations on that.

DR LUXFORD: Sure. Look, we've recently done costings ourselves on running a program that was available to every family that birthed just in a small area of the ACT, which has about 6,000 births a year and, yes, it was expensive to do it in that way. We were looking at if you just offered a four-week drop-in type of course where you'd have specialists each week speaking to people and just providing those tools around wellbeing and recognition and self-care; all of those things. And then following that up with a dedicated psycho-educational playgroup while the baby is still immobile, so you have that kind of focus as well, and it's not cheap to offer that to everybody, that's true. When you look at it and the comparison of $7.3 billion that you're looking for every cohort of births in the country, I think it balances out more, so I haven't done full costings for the whole country on what a program like that would be.

Yes, you could certainly - I mean, it would be wonderful to add in that wellbeing side of it to the regular antenatal programs as well. Many people attend private antenatal programs so I don't know how much you would be able to encourage those private providers to change to add in that aspect. They may feel that already the curriculum is full and that's not what people are wanting.

We could certainly look at providing that kind of program to a targeted cohort, to people who have experienced mental illness in the past or who have experienced specifically perinatal mental illness in the past or potentially if we are screening with a high quality tool, those that we are identifying who may have problems at that point in time.

PROF KING: Yes, just on that screening side because again thinking from a consumer perspective, you know, I can imagine there could be some concerns that, 'Oh, you know, I'm being profiled almost just as they are. Well, I'm in a higher risk group' and that's sort of saying something negative about it because we are in a space with a lot of stigma. Again, do you know if there's work, either formal work, on those sort of screening tools and in particular on consumer engagement with those tools, consumer views about those tools and is there evidence of either positive engagement or negative feedback from it?

DR LUXFORD: Certainly with the EPDS which is most commonly used at the moment there was consumer engagement in its development, there's - I've not - we use it ourselves, I've not heard anything negative about its use. It's often used, there's - you know, universal screening is really down to practitioner application, if you like. I mean, it's in a lot of policies that everybody would be screened antenatally, that doesn't mean everybody is, it's down to what their practitioner might do.

I absolutely hear what you're saying about stigma. When you were speaking before about stigma around small children in mental health I think that's a very big issue when it comes to parenthood as well. We're expected to magically be good parents. It's very much what's portrayed to us in the media and social media especially. You feel, personally feel, that you're failing if something's picked about you in terms of your parenting. So it would need to be managed well but as I said at the moment people are screened. Usually, I mean, you're screened antenatally frequently as I said but the opposite side is you'd be screened if you entered a program or you'd already self-identified that there were some problems so I hear what you're saying and I'm not sure if there's been any work done on that more generally.

MS ABRAMSON: Can I make a follow-up question which really flows from what you were talking about. Is the use of peer workers in perinatal mental health and if you've got some comments about that because you did talk about stigma and social - you know, the perfect mother on Instagram so I'm really interested in your views on that peer worker point?

DR LUXFORD: There's certainly some programs that are run across the country. One excellent one is Peach Tree run out of business who everything is through a lived experience lens, all of their counselling et cetera that they offer, so they very heavily rely on peer workers. So different programs use different methods. We don't in our program. We use mental health professionals rather than using peer workers in what we do but we definitely find that if we're lucky enough to have X clients you are willing to share their stories that really resonates and every time we do media where we're using people talking about their own stories, that's when our number of enquiries really peaks, yes.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Can I just ask a follow-up question as well. So you said that your service covers up to the age of two so I guess one of the issues across the service continuum is the links between programs that sort of either are age bracketed or geographically bracketed so if you have a family with an infant who's struggling in the second year and this is going to need ongoing support or even treatment, is there a connection between what comes next after your service sort of ends?

DR LUXFORD: That is quite difficult. We do refer on to other services whether they're private psychologists or we have a range of people that we would refer directly to that we'd have a relationship with but it's definitely a problem in that time delineated space. In Canberra, here there's actually a government run perinatal mental health consultation service which has psychiatrists, psychologists and Allied Health professionals working within it but their timeframe finishes at age one.

PROF WHITEFORD: Right.

DR LUXFORD: And they don't care for dads at all or partners, that's only for the mum. So it's definitely a problem having those restrictions of people entering the service and, no, there are no nice clean fluid flow throughs from one service to another.

PROF WHITEFORD: Yes, okay. That's good. Not good to know but it's good to know if you know what I mean.

MS ABRAMSON: It's another gap, Harvey.

PROF KING: Good to know, not good to (indistinct words).

PROF WHITEFORD: Yes.

PROF KING: All right. All done?

MS ABRAMSON: Yes, thank you.

PROF WHITEFORD: Yes, thank you.

PROF KING: Okay.

PROF WHITEFORD: Thank you very much.

MS ABRAMSON: Thank you very much.

PROF WHITEFORD: Thanks, Dr Luxford.

DR LUXFORD: Thank you very much, thanks.

PROF KING: Good morning, Ms Rendell. Would you be able to state - the microphones by the way are just for the recording.

MS RENDELL: Okay, yes.

PROF KING: Would you be able to state your name and your role, your interests in this inquiry, for the transcript?

MS RENDELL: Yes. Okay, so I'm Diana Rendell, I'm currently working in mental health. I transitioned from the Partners in Recovery program, we were support facilitators. I'm a social worker doing a master's in social work but I've had the last sort of four years in that PIR program which is unfortunately transitioned or funding stopped with NDIS. But I did read through the report and I'm very interested and I'm very happy with a lot of the recommendations. So I guess I sort of feel I want to speak for my clients.

PROF KING: Yes, please.

MS RENDELL: Yes, because I sort of - yes, they share so much and I'm - you know, they don't often have that opportunity to sort of speak but I did notice, you know, in the first part of your report was about the mental health system being sort of essentially tacked onto the physical - as a physical health system and that's sort of my experiences that people present with symptoms and most often it's rooted in some sort of trauma whether it be childhood or trauma throughout life and often it's multiple layers of trauma but that's not usually dealt with.

It's usually the symptoms and then it's the dominant medical model which is prescription medication and, you know, that is effective in a lot of cases but generally, you know, the clients that we deal with in Partners in Recovery they are severe and persistent (indistinct words). But it seems to me that their trauma is never addressed and until their supported in working through that - I mean, there may not be healing but it's manageable. I think it's really a revolving door (indistinct words), you know, a lot of them are just permanently on medication. You know, their sort of medical health is they go to the GP and they get prescriptions, they might have a psyche review every 6/12 months but they drop out of the system, - they drop in and out of the system.

So that's where I found our program very effective in helping people to stay involved/engaged and continually linking them with appropriate services. And I did notice too in that you mention coordination of services as important and it's vital because so many of them fall through the cracks. You know, they don't want to get out of bed in the morning so it's - you know, someone in our program will go the extra step for them and I know that the mental health system, the local health district, they don't have that role in their crisis management so, you know, they stick to their role, the GP sticks to his role. So I think in our role it was collaboration to linking everybody together and, you know, you mention care plans.

Well, we had what we called 'action plans' which, you know, describe very well the care plan. I know they have care plans in the medical but ours was setting their goals for their own recovery or at least management of their symptoms. But, you know, overall I thought the recommendations were spot on but I sort of fear the dominant medical model, the dominant economical model, the now liberal of system that we all live under which exploits the vulnerable, how we ever challenge that and change that but - - -

MS ABRAMSON: Ms Rendell, can I ask you a question? Just - without using names, of course, if you could describe for us the type of services that you're talking about because the actual example of how you went about doing your job in Partners in Recovery is really useful for us.

MS RENDELL: Yes, okay. Well, we most often get referrals from either a GP or the local health district community mental health but anyone can refer and people can self-refer (indistinct words) but most of them they'd come through and they would have presented through Access Line or to the hospital with perhaps a psychotic event or just - you know, most of them are overwhelmed with life, you know, and they present in crisis. So I haven't worked in the local health district so I really only can sort of give my opinion of the procedure.

PROF KING: No, that's fine. We - - -

MS ABRAMSON: No, we're interested in your actual experience of delivering the services.

PROF KING: Yes.

MS RENDELL: Yes, okay. So I would get a referral, I would contact a client, we do our needs assessment with them which a lot of them were homeless or poverty - poverty is another common denominator I'd say first trauma, poverty. They never seem to get - the trauma's not dealt with, they never seem to get out of poverty, they feel more and more worthless because they can't do anything, that's no money. That's what I'm working with all the time.

MS ABRAMSON: Yes.

MS RENDELL: And we do have funding things so we can help them through and I had a client only a couple of weeks who said, 'I'm so sick and tired of being rescued, you know, with a $50 voucher'.

PROF KING: Yes.

MS ABRAMSON: Yes.

MS RENDELL: 'I feel like I'm just scum', you know, they say that and it's like you're trying to lift them out of that sense of worthlessness, you know. But, I mean, we then would refer to appropriate service. Say, for example, they might be homeless we'd help them get onto the homeless but then there's a waiting list.

PROF KING: Yes.

MS RENDELL: You know, with all of those social disadvantage - you know, the structural disadvantage that they face those things seem to be endemic and not changing and in fact I think they're getting worse. So until we address it holistically, you know, it's band-aiding essentially. Yes, so we would refer onto appropriate services and there could be five or six services involved. We meet with all those services with the client and we support the client in setting their goals. You know, and most of them are never in a space to set goals, they're only ever surviving.

MS ABRAMSON: Yes.

MS RENDELL: You know, so we can have all these theories of wonderful action plans. You know, it's on paper, it looks wonderful and you can tick the box that you've done your action plan every three months which is exhausting for the worker.

PROF KING: Yes.

MS RENDELL: We've got to tick all the boxes but until they can sort of, you know, deal with the issue of their trauma whether it be some sort of abuse and often it's ongoing too, you know, they go from a childhood trauma into a relationship trauma of domestic violence, drug and alcohol - it's just a downward spiral in a lot of cases but, you know, there are some good results too. And I see people when they do get a little bit of financial relief they pick themselves up and they start to, you know, develop their creativities. 'What can I do?', you know, 'I'm actually okay' and they can go and then develop their creativity so I think those two factors, if we could fix those two factors; the poverty and dealing with the trauma.

MS ABRAMSON: No, no, thank you. If you don't want to discuss this it's fine but I understood that you wanted to talk to us about some research from Melbourne University?

MS RENDELL: Yes, I'm always looking at solutions and I wanted to bring a copy but I can send it in anyway.

MS ABRAMSON: You can send materials to us.

MS RENDELL: But it was a study done in 2012 at Melbourne University.

PROF KING: Yes.

MS RENDELL: Recommending the Government include neuropsychological assessments into the mental health system or indeed the health system because the link there with cognitive, and I've seen this with several clients to the cognitive impairment not necessarily a mental illness, so they recommend that if when these people present to mental health units they then are assessed. They have a neuropsychological assessment to see if there is a brain injury. You know, even I've had a client with foetal alcohol syndrome that was never mentioned in all the notes. I went right back through the notes and no mention of it but I could see some of the - I mean, I'm not an expert at all, I'm not a psychiatrist/psychologist, but I'm always looking for, you know, - - -

PROF KING: Signs.

MS RENDELL: You know, and I would notice he would write his letters the wrong way and I thought, 'Oh, dyslexic' and I talked to him about that. He didn't have a clue, we got the school records, there was no mention of it so I was really pleased to see that the early interventions into schools is going to be wonderful but there's also those generations that have come before. You know, like I've got a 19 year old guy and he's dyslexic.

PROF KING: Yes.

MS RENDELL: He's had multiple traumas so he's not going to get that early intervention. So if they could introduce it to the system for everybody when they present, that they do those neurological assessments, but that report was wonderful and it gave savings to and the costings as well, so.

MS ABRAMSON: Because that as I understand it is related to your issue of misdiagnosis; that's really what you're saying there.

MS RENDELL: Thank you for reminding me. Yes, that's the thing, that's what I was just sort of touching on because this particular with the foetal alcohol, he's currently - well, when I was with him, he's no longer with us - but he's still being treated for schizophrenia and he may have as well, I'm not disputing the psychiatrist but that was the focus. Seemed to be a tunnel vision. Once you're diagnosed that's what you are and if I - a couple of times I've questioned not in a, you know, not in an arrogant way as, 'I don't agree with this', I've just asked, you know, 'Have you considered this, that and the other?', they don't like it. They don't like you questioning. And this boy, he's 12 now, he has monthly injections for schizophrenia, clearly foetal alcohol syndrome.

PROF KING: Yes.

MS RENDELL: But from my readings on foetal alcohol, a lot of the GPs are not aware of it.

PROF KING: Okay.

MS RENDELL: And only through my own training have I become more aware of it that you don't necessarily have to have the facial symptoms which is what I had thought before I did training. Only 10 per cent or a small percentage of people with foetal alcohol have facial symptoms. There's a lot of people that do have those symptoms without the facial so it's not diagnosed.

PROF KING: Yes.

MS RENDELL: I just think, you know, if there could be a real thorough diagnosis then once you get the diagnosis - you know, there's never probably going to be perfection or certainty but once you could fairly clear you can then streamline the treatments.

PROF KING: Yes.

MS RENDELL: But at the moment it seems to be the favourite diagnoses, bipolar or, you know, schizophrenia and then that's the path they go down and to get off that path - you know.

PROF KING: Yes.

MS ABRAMSON: Well, one of the issues I think, you know, we've spoken a lot about the mental health system being tacked onto the physical health system so just an observation is that just as the diagnosis, it enables people to get the psychosocial support so there's a link between saying you have a mental illness and therefore you're entitled to X, Y and Z; it doesn't answer your basic premise but it is a bit about the design architecture of the system and, Harvey, you might want to comment.

PROF WHITEFORD: No, I think you're right. I think it's about that multidisciplinary assessment about the complexity isn't just about a single diagnosis, it's about physical comorbidity, drug and alcohol as you said, history of psychological and physical trauma which could be traumatic brain injury.

MS RENDELL: Yes.

PROF WHITEFORD: And the environment of which that person goes back to in it with you or with their clinician.

MS RENDELL: That's right.

PROF WHITEFORD: And all of that plays a role and we're looking at it through one particular lens but if we're clinicians or health workers - but trying to pool that together with that level of complexity has really been the challenge and I think the recommendations around, you know, single care plans or, you know, so that - and everybody can see what everyone else is doing in that the consumer especially in their care of family, if they have one, is able to be part of that and a central part of that might start to pull it together but it's been an enormous challenge given how funding comes down these stovepipes and connecting up the dots and asking someone who has a mental illness to connect up the dots, you know, it's a challenge.

MS RENDELL: Yes, very challenging, yes.

PROF KING: I want to follow up on that and ask about Partners in Recovery and your experience of that. So I guess our vision in our recommendation is that care coordination and someone mentioned - you're just reinventing Partners in Recovery - - -

MS RENDELL: Well, that's it, that's what I thought.

PROF KING: So the care coordination but not just for the community psychosocial supports but also linking in the clinical system so a full coordination role; was that what Partners in Recovery was or did you actually have a role as the interface with the clinical system or not?

MS RENDELL: Not necessarily. We were supposed to be like short term as well just to - when they were presented to the local health district who referred to us, we would then pool everything together so do the needs assessment, what's happening, you know, what they need, what's the crisis, you know, and it's designed - it was designed sort of to be short term and then get them on their way but then every three months we would meet with the GP, the counsellor, the clinical at mental health, whoever that person was linked with, to have the meetings to see how things were going, see how things were progressing. But again the administration involved, because again you've got to meet targets, that sometimes can become the focus from up above us, the people on the ground, the social workers who are, you know, really working face to face with the pain that these people experience, that's a dilemma for us. You know, got to spend so much time doing all of this box ticking when nothing's happening.

PROF KING: Yes.

MS RENDELL: You know, I have to say what a great program it was but because the system is band-aiding and focusing mainly on, you know, medication not a lot of - and of course the economics, you know, poverty that's entrenched, they go out in the environment. Not many people improve, you know.

PROF KING: Progress, yes. Can I ask the dialogue for me is where you'd have perhaps a psychiatrist, perhaps a therapist and yourself; how did you find that in terms of experience?

Were you treated, you know, as the add-on or were you treated as an equal or was it a case of, 'Well, certain disciplines sit at the top of the pyramid' and - - -

MS RENDELL: No, well I was banned by one psychiatrist because I asked the question.

PROF KING: Okay.

MS RENDELL: I asked a question as to why injections were necessary and I wondered why, you know, this assessment wasn't done for dyslexia and those sort of things, you know, and I'd said, I'd been to the school to find, you know, these things, and just shut me down, yes. And other workers had had similar experiences with the local health district. It seems to be a defensive attitude of, you know, hanging onto their power and, I mean, I respect psychiatrists, I respect all those workers, everyone's doing their best, but I think we need to be open.

PROF KING: Yes.

MS RENDELL: And a little bit flexible. There's a possibility - and maybe listen to people who are actually face to face, they'll see the clients so often, whereas a psychiatrist might see them every three months/six months.

PROF KING: Yes.

MS RENDELL: So you get a real sense of what's happening but I think traditionally, you know, it's been that way anyway with - social workers do have a bit of a hard time in the medical field because we sort of work from a social justice perspective, you know, about equality and human dignity, integrity and all of those values whereas it might clash with the economic muddle of competition, you know, and all of those. There's always going to be those clash of values but I'm not demeaning people at all, I don't mean to be like that.

PROF KING: I understand.

MS RENDELL: But I do get frustrated that why can't we be open, you know, find solutions because, I mean, the amount of money that's going into different programs to help people and, you know, we really do want that.

PROF KING: Yes.

MS RENDELL: But we've got to open up that - or, you know, change the medical model by integrating other sort of models with it. I mean, I know the social model's still there, it's psychosocial model two, but it seems to be medication. I haven't had a client that hasn't been medicated for something. Some of them are on 8 to 10 medications, they don't know why. So the first thing that I do is we go to a GP and we get a mental health care plan which is mentioned here as well and I always explain the side effects and they say, 'Well, why didn't the doctor tell me this?', you know, they don't have time essentially or they're a 15 minute/10 minute consult so I do the holistic thing and I say, 'This is what you're on and why you're on it and these are the side effects' because they can say to me, 'Oh, I get these, you know, this dizziness' or whatever it might be and I'll say, 'Well, this could be - so how about when we go to the doctor next time we talk to the doctor about this?', you know, so I'm' trying always to - and that's what social workers do, empower the client, empower them to be in charge of their health and their recovery because all of them, I haven't had one that hasn't felt like they have agency, they have choice.

PROF KING: Yes.

MS RENDELL: A lot of them say, 'Do I have to come today?' and I would say, 'You don't have to come. It's totally up to you', you know, always have to reinforce that.

PROF KING: Yes.

MS RENDELL: So they're that sort of disempowered that they feel like, 'I've got to go' and I'm always telling them, 'No, you have a choice' unless of course there's a CSO in place.

PROF KING: Yes.

MS RENDELL: Yes. So we go through that and some of them are just amazed with these side effects. I mean, some of the antidepressants actually can give suicidal ideation so I'm thinking, you know, 'Wow, what's happening?', you know, and the clients say that to me as well so there are some real major concerns with some of them so I always go to the GP - they don't like it, they don't like being questioned. Most of the, some of them are okay and they'll say - - -

PROF KING: Yes, (indistinct words).

MS RENDELL: Yes. And I've even had a couple recently in different towns, because I travel a bit now, GPs have said when I mention PIR, 'Oh, can I refer more patients?' and I said, 'No, it's finished', 'Oh, why didn't I know about?' so that's another thing too, a lot of them didn't know about Partners in Recovery as well. But I was only reading an evaluation on the program that was done a couple of years ago, I think it was Flinders or one of the universities, and everything was positive.

PROF KING: Did you see an essential role in Partners in Recovery as a coordinator, I guess we've called it a 'coordinator', but a lot of what you're talking about is almost helping empower the consumer so did you see that as part of Partners in Recovery or was that more your personal experience or?

MS RENDELL: Well, sort of the mandate for the Partners in Recovery there's walking beside them on their journey to recovery, yes, so we always - and I guess the social worker to also have in mind, you know, human rights, client's rights, self-agency, empowerment, all of those goals.

PROF KING: Yes.

MS RENDELL: It's not directive, I mean, unless there are cases of course but we, you know, try to convey to the client and support them in realising that they have the power to get well.

PROF KING: Yes.

MS RENDELL: They have the power to make the choice because of course there are people who want to remain a victim as well as it's very challenging but, yes, it's sort of a holistic program but I think one of the most challenges as I said is the system, working with the system, getting the systems to support what we were doing as well.

PROF KING: Yes.

PROF WHITEFORD: I've got one more but - - -

MS ABRAMSON: I've just got one more because rather fortuitously for us you come from a regional area so we're really interested about the delivery of psychosocial supports in the regions because we have had quite a bit of evidence to us but we use an economic term, they're thin markets, there really aren't enough people providing the types of services so I'm really interested in your experience?

MS RENDELL: Well, services are wonderful for disability.

MS ABRAMSON: Yes.

MS RENDELL: But mental health services, we've got the local health district and we've got a couple of - I think there's Flourish and the new one, 'Wellways'. I think there's one person working from the local health district but that's the thing we're finding too and a lot of our client - well, we have to transition our clients to NDIS and I'd say 75 per cent are not getting through NDIS and mental health clients.

PROF KING: Yes.

MS ABRAMSON: Because they don't qualify for NDIS, they're making the application and then rejected?

MS RENDELL: Yes, we do the application which requires psychiatric evidence and those things as well but they're getting rejected so that's why we've got the continuity of supports of people to transition to those.

MS ABRAMSON: Yes.

MS RENDELL: But we don't know what that looks like so I'm wondering what's the coordination going to be like in these new - because the transition in which - it's just been commissioned by the PHN to Wellways but we don't know - we haven't seen whether it's going to be intensive support that PIR offer because if not, we're going to go five years down the track and we're going to, 'We need a PRI again' or something like that where it's more holistic but, yes, the services in region, you know, that's the thing, we do have people with good NDIS packages but there's no providers. So they've got this fund to do this and that, and they come along. They want to do things, but there's nowhere. See, I'm in a small town, but - Wagga's an hour away, but they're pretty much exhausted as well.

So, yes, it's just - I don't know. It's just hard to put your finger on. It's great. I think there's plenty of money available in mental health, and government does provide it, but it's all misdirected. Not all, sorry. A lot of it's misdirected with mistreatment, misdiagnosis. You know, they just can't seem to pull it together, and I think, as I said, it's a bit of a change from the dominant medical and economic models, but then again, that's a big challenge for everybody.

But yes, the last thing I did want to say was, I had - I've had many clients say to me, because of these short-term block funding things, 'So how long are you staying? I just get to know somebody, and then you're gone. I just get to like you, and then I've got to get to like somebody else. Why do they do that to us?' And other PR workers say the same thing.

PROF KING: Yes.

MS RENDELL: So, that's a voice from the clients. Because, you know, with the trauma and that, the trust is broken. So they always feel, if you don't answer their phone call, you've rejected them. Abandoned them. They always feel that, so we work really hard and then, I'm sorry, I'm leaving.

PROF KING: Yes, which is - - -

MS RENDELL: Yes, so that's a - - -

PROF KING: **- - -** breaking trust again. Yes.

MS RENDELL: - - - an important thing. Yes, because if they can't build up the trust with their worker, they're - you know.

MS ABRAMSON: But thank you very much for coming today, and it's never easy when you're an individual person speaking. So thank you for making the effort, you know, really for your clients as well.

MS RENDELL: Yes, I did that. That was what motivated me, was I wanted to have that - that sort of voice for them.

MS ABRAMSON: Yes. No, thank you.

PROF KING: Thank you.

MS RENDELL: All right. Well, thank you so much for the opportunity.

PROF KING: Thank you. So, we've actually got a little bit of time before the lunch break. Normally in these hearings, we allow time for individuals who haven't officially said, yes, we want to register to present, and who are observers that have no, or decided, no, I really want to make a statement or put something on record. So I'd like to use this time for that. So please, if you can come down and take a seat, and just state your name for the record.

MS ABRAMSON: Just so you're aware, if you weren't here before, it's transcribed. So it's a public process.

COLIN HALES: Colin Hales. I used to be a health care advocate up until I actually tried to make use of services, and that led to my becoming completely disengaged and homeless, as a matter of fact. But the main problem I see here today, and it was highlighted by the trauma comment there - Fay Jackson made the same comment on One Plus One recently. The reason that trauma features so heavily in the past history of a lot of us is not just that the trauma creates psychological issues that we have to resolve, it's trauma - unresolved trauma is a type of inflammation.

Unresolved inflammation for years and years and years creates other problems. And this is where the Productivity Commission is also going wrong, in you're separating out mental health from physical health, and then you're focusing on mental health as if it's social and emotional, and whether some of it is in fact neuropsychological. I've got a brain injury there. My main goal in seeking mental health care is, can you explain why drugs help this recover, and for 19 years it's been, 'No, they don't. You went crazy.'

So the pre-screening, if you're going to screen people for social and emotional, you need them to take the next step and actually consider, well is there a foetal alcohol syndrome, or dyslexia, or some other organic physical condition that is creating the precursors and the psychological or emotional problems. I'm glad I got a chance to say that.

PROF KING: No, no. So, if I can try and summarise, and I think it's a really important point. So are we potentially falling into a trap or a mistake where we've said, there's a mental, mental illness bucket here. There's a physical health bucket here. We're aware of the comorbidities, but are we in a sense looking at the comorbidity, well, you may have psychosis and diabetes. But if I understand what you're saying, and - - -

COLIN HALES: Diabetes also actually runs a lot off inflammation as well, and magnesium deficiency. Not just diabetes and sugar, but anyway.

PROF KING: If I've got right what you're saying, it's when we - you know, in a sense, when someone steps through a door and up, you now - let's triage, let's work out what's happening here. But we have to be very careful to make sure that we're doing that from both a physical health and a mental health perspective at the same time, because it seems that at the level of the workings of the brain, they are intimately connected.

COLIN HALES: Well, in the old - the old DSM, it used to say, you know, at the end of every entry, 'Not the subject of other health condition.'

PROF KING: Yes.

COLIN HALES: And from my experience of using systems, is that doesn't - that doesn't - as soon as you present with a mental health, or agitation, or anything that makes people think, that's a mentally ill person, that all goes out the door. You know, the physical health checks are just rudimentary, and they really - they should be more - more pronounced.

PROF KING: Yes.

COLIN HALES: Or more in depth, I guess.

PROF KING: Yes. Because I think we - we do refer to that briefly in our report. We refer to it as stigma in the health system, so that once you're up, you have a mental illness and then everything is put to the mental illness.

COLIN HALES: Yes, and it's even if you haven't got diagnosed as a mental illness, it's if the clinician thinks you're mentally ill, they will respond to you as if you're mentally ill, no what you're pursuing. And just on the terms of the medical model. We don't need to change. We don't need to throw it out. We need to get rid of the broken medical model, the model that says that it's about chemical imbalances, and not about inflammation and actual biology.

You know, functional biology. The science is out now. Well, more or less. You don't need to change the system until you change the understanding that's underpinning the system. You need to move further back before you start tinkering, if you know what I mean.

PROF KING: Yes.

MS ABRAMSON: Mr Hales, could I ask you about some of the support services, as a person who's experienced this system, where you think that we should be looking to do more, or particular things that would make a difference?

COLIN HALES: The whole information sharing is a worry for me, because it's not accurate information. So I avoid seeking services because they'll just share information. It's also that treating people as clients as below the - below the community sector, and below the - it's - so it's seeking out. I went to a local church recently, and I just delivered stuff to them, and then did a shop at their fête. And that was good, because I was there as a member of the community, not as a client. So I could be as rude to them as they normally are to me. But they're normally quite respectful, I should say.

MS ABRAMSON: But Commissioners.

PROF KING: Sorry, can I just follow up on the information.

COLIN HALES: Yes.

PROF KING: So you avoid services because you're concerned about the information. Is that because - well, if you had more control that information, in the sense it was recognised as your information, would that make a difference?

COLIN HALES: Yes, yes. I mean, if I could - if I could have a reasonable input into My Health Record, I would probably have a My Health Record.

PROF KING: Okay.

COLIN HALES: Clinicians will have one conversation with you, and then - I advise this to everyone - get a copy of their notes, because they've often written down something entirely different to what - the conversation they had with you.

PROF KING: Yes.

COLIN HALES: Don't do if you're not willing to be debilitated by it though.

PROF KING: Although some clinicians feel they own the notes, which I occasionally point out, legally they don't.

COLIN HALES: Yes, I know, it's - that's a fraud issue for me, but you know.

PROF KING: Yes. Okay. Other questions, comments?

MS ABRAMSON: Thank you.

PROF KING: Thank you very much.

COLIN HALES: Thank you for giving me this opportunity.

PROF KING: No, thank you.

COLIN HALES: Thank you.

PROF KING: That was fantastic. Next, please. Would you like to come down? And again, if you would be able to state your name and - - -

MS O'BRIEN: My name is Lauren O'Brien. I'm a staff member from the - from ADACAS, which is the A.C.T. Disability Aged and Carer Advocacy Service. We work with people with disability, people with mental ill-health, older people, and carers, and there's - many of the themes that have been brought up today that are very pertinent to the issues that arise in the advocacy work that we see.

PROF KING: What would you like to tell us, I guess?

MS O'BRIEN: Okay. I wanted to, I guess, support some of the comments that have been coming up about the need for Care Coordination, and for Care Coordination to be an ongoing service. Some of the challenges, as was mentioned, I think by Diana Rendell earlier around, particularly people with complex needs, finding that they are being - they see a service for a very short period, and then they're no longer able to continue with that service, because of the duration of what that program is offering, means that especially people with the most complex of needs can find themselves becoming disenfranchised from the systems, full stop.

And especially when there are clients, and many of the clients at ADACAS actually have experienced many, many, many challenges and trauma and abuse, and that emphasis on being able to create a relationship with service providers, if there's a scenario where you've already told your story to someone, and it was hard to tell, it gets harder and harder for people - - -

MS ABRAMSON: I understand.

MS O'BRIEN: - - - to feel comfortable.

MS ABRAMSON: I understand.

MS O'BRIEN: Yes.

MS ABRAMSON: Sorry, you go on.

MS O'BRIEN: No. So, I guess also just the emphasis on the need for a human rights approach, and particularly supported decision-making approaches.

MS ABRAMSON: That is exactly what I wanted to ask you about, which was - so please continue.

MS O'BRIEN: Yes. So supported decision-making. ADACAS, at the present time, has been doing work in supported decision-making in the health care realm in the ACT, and looking in particular about what's - what can be done to improve the way that support is offered. There was conversation earlier this morning about idea of involving, or to better involve family and supports with someone. I would contest or argue that supported decision-making is an excellent way, and an excellent frame to look at that approach through.

Because if you're starting with people by looking at how do we best map you support network, who's in your support network, are there any gaps in your support network. Are there ways we could fill those gaps? How do we work with you? What's important to you? How do we prioritise?

MS ABRAMSON: Lauren, can I ask you, for the benefit of the transcript, what you define as supported decision-making?

MS O'BRIEN: Yes, absolutely. So supported decision-making is about a way of working with an individual that looks at how that person defines the support, but also how support is offered to that person in a way that best suits their needs. So that might mean - so supported decision-making is something that can be offered by anybody.

MS ABRAMSON: Yes.

MS O'BRIEN: And it's about understanding the information and views of the person at the centre of the circumstance, and what support they might need that might be different to the support that's needed by other people. So, if one individual might - might say to you, support for me looks like this, and then the system being able to understand, okay, so that's the support that's needed in that circumstance, and if that involves - the family member needs to be present at these particular instances, or we need to write information down in easy English after the end of each appointment, or whatever it is that's required around what those support needs are, and people getting an equitable experience of the health systems, or of whatever system it is that they're trying to interact with.

MS ABRAMSON: It's a really interesting conversation, because we've thought of supported decision-making in a narrower context. We've thought of it in the context of mental health tribunals.

MS O'BRIEN: Yes.

MS ABRAMSON: And people having support and advocacy, not just legal advocacy. But you're encouraging us to look broader than that.

MS O'BRIEN: Absolutely. So, ADACAShas been doing work around supported decision-making in health care settings.

MS ABRAMSON: Yes.

MS O'BRIEN: So whether that be hospitals or working with GPs, and assisting - I guess because there's so often a scenario where if it's a person with disability or mental ill-health, there's assumptions made about - - -

MS ABRAMSON: Yes, I understand that.

MS O'BRIEN: - - - what someone might - rather than actually checking what support looks like, and how best that person would prefer support be offered.

MS ABRAMSON: I don't know if you were proposing to make a submission to us, but if you are, I'm mindful that there are always resource constraints.

MS O'BRIEN: We did make an earlier one, and we're happy to make another one, and we will certainly make sure that we focus on supported decision-making.

MS ABRAMSON: And just some practical examples.

MS O'BRIEN: Yes.

MS ABRAMSON: That's really helpful for us. So to say, well, in this example, this is actually, when you ask the person, it's a bit like the NDIS. What does the person actually want? I'm not talking about the performance of the system, but just the consumer at the centre.

MS O'BRIEN: Yes.

MS ABRAMSON: So that would be really helpful.

PROF KING: Yes.

MS O'BRIEN: Well, supported decision-making, in lots of ways, is a process about people having the right information in the right way at the right time, so that they can actually take control of the decisions that are occurring for them.

PROF KING: Yes. It strikes me that your discussion of supported decision-making is really a tool of consumer empowerment.

MS O'BRIEN: Yes.

PROF KING: Because they're able to say, look, this is how I need the information. This is the person that I would like to have with me.

MS O'BRIEN: Yes.

PROF KING: I'd be very interested, if you've got examples when that goes into clinical setting, and you say that this goes in there.

MS O'BRIEN: Yes.

PROF KING: As to how that is received by clinicians.

MS O'BRIEN: So, there's many clinicians that are quite receptive in that space. The change in the Mental Health Act in the ACT is starting to bear fruit around understandings of that. But there continues to be much work to get culture change across the board, and certainly the experiences of having - the example given earlier of being shut down, as opposed to people being given the information in the way that they need, at the right time, is unfortunately also not uncommon.

PROF KING: Are there legal barriers that - you mentioned the ACT, but are you aware of whether there's legal barriers, either still within the ACT, or elsewhere around supported decision-making? So just simple issues like, well, you can't have that person here because you haven't signed form X, Y, and Z, or - - -

MS O'BRIEN: So, I guess the thing that I would say is that many of those are actually traversable.

PROF KING: Yes.

MS O'BRIEN: So generally the thing that's needed for a different person to be there is consent from the person themselves. If they are happy to consent that I want this person there, then that actually should be being respected. So I guess it would get where you would get to some of the legal barriers, would be around - or where you would get to some of the additional barriers would be around comfort levels of the staff, and experience of the staff in actually working in a way that supports decision-making in this space, and including whoever that person wishes to include in their support network, as part of how they process.

Because families and carers can be an incredibly important and vital support, but it's not necessarily a family or carer that a person will go to, or that would want - when I had this sort of issue, I might go to this friend. Or when I had that sort of issue, I discuss with my lawyer, or whatever it is that the person has - whomever that person has already in their network.

PROF KING: And we heard Mr Hales mention the actual - your records.

MS O'BRIEN: Absolutely.

PROF KING: And the medical records, the file notes and so on. I can imagine that's also something that many consumers would be interested and say, well, I like a copy of that, or I'd like a summary of that.

MS O'BRIEN: Yes.

PROF KING: Do you find that that's usually - where that's asked for, how is that request received?

MS O'BRIEN: So, of course, consumers are legally entitled to their own records. There is more work to do around the power difference that occurs in settings with expert - well, with senior doctors or psychiatrists, sometimes, around understanding the responsibility and the obligation to provide reasonable adjustments, is a legal obligation, and if that means that - and so if that means that they need to provide information differently, or that they need to have the notes, like written in front of the consumer and a copy given to the consumer at the end of the meeting, that notes are written in a way that is respectful, and that is going to be conducive to the person understanding.

So, I guess it's both the clinical record in the background, but also the information that's provided to people to enable them to make decisions that suit best to them. Just the other thing with that would be - and just around, I guess, the information provision right side of it, is just around if someone is really unwell, then what - if someone just finds the receipt of notes or information like that distressing, then they need to be supported around how that happens too.

PROF KING: Yes.

MS O'BRIEN: Some people, absolutely getting your notes will be the - will be a very empowering thing, and they'll feel very able to contest then. No, you wrote this. That's actually incorrect.

PROF KING: Yes.

MS O'BRIEN: This is what I said. Other people might find that that - that reading incorrect information and notes so disheartening that they - they - that they - - -

PROF KING: They need to be supported in that process.

MS O'BRIEN: They would need support to actually challenge; that's not how - that's not what we covered, and you've missed these key points that we - that occurred in that meeting.

PROF KING: Yes.

MS O'BRIEN: So, yes.

PROF KING: Okay. Thank you very much. Other questions, comments? Well, thank you very much for that.

MS O'BRIEN: Thank you.

PROF KING: Thank you. Anyone else at this stage who would be interested in making some comments, observations? No. Well, in that case, we're a little bit early for lunch, but why don't we break for lunch.

PROF KING: Thanks.

LUNCHEON ADJOURNMENT

(Telephone link established.)

PROF KING: Excellent. So again let me just very briefly reiterate some of the details before we formally get started. Ben won't need to know this but there are microphones in the room there purely for the transcript and not for amplification. It is a public hearing and so there is a transcript taken. The transcript will be made available on the website following the hearings. I notice we don't put days and as to how long but it will be up as soon as possible. Submissions are also available on the website.

We know some of you are going to speak from personal experience. Please be aware of privacy protections and refrain from naming specific individuals and if any of the members of the media have come in over lunch please make sure you identify yourself to staff. Given the nature of the proceedings please be respectful in your approach and please put your mobile phones, I including mine, on silent.

So our first person after lunch. Ben, do you mind stating your name and organisation just for the transcript?

MR McMULLIN: Sure. Ben McMullin from Batyr, B-a-t-y-r.

PROF KING: Thanks. And do you have an opening statement you'd like to make, Ben?

MR McMULLIN: I just have some (indistinct words) to mention and I might just give a little bit of structure around what sort of things I can talk to.

PROF KING: Yes.'

MR McMULLIN: Because, yes, if I can just jump into that now if that's all right with you in Canberra?

PROF KING: Please, yes.

MR McMULLIN: Fantastic. So I just wanted to say on behalf of Batyr we're really grateful to be part of this conversation. I think it's a really important and timely thing for the country to be looking and we're really excited about being involved in the conversation in some of the points that are coming for recommendation as well as some of the conversations that are occurring around the release of this report and the way the report's being created is really positive for Australia and I really want to commend the work of the Productivity Commission putting them together and for including a lot of the formulisation in the process of delivering this report so I just wanted to acknowledge that.

And also I wanted to touch on that three elements of Batyr's submission - we made an initial submission before the draft report and we've made a statement about that report, which I will touch on a bit in a little while, but three sections have been really important to us and I think these three elements have really come through on the draft report and in some of the conversations around it particularly around prevention and education to reduce stigma and creating a stigma reduction strategy around the country for coming out of this report is a really fantastic recommendation and alongside with that the power of sharing realistic experiences to create increased (indistinct words) behaviours in people who are struggling with their own mental health has been a really fantastic element to see in the draft report and in some of the more detailed responses to some of the challenges that have come up.

So we've been really (indistinct words) those two things and also we're really excited about the community building element of the report in particular around trying to increase social inclusion and reduce isolation for young people and, yes, I think they're the points that I really wanted to touch on. I really wanted to thank you much for having us on board. I do have a couple of responses to information requests and draft recommendations from within the report itself. I'd be happy to talk both to those or alternatively we can put that into a formal submission for you over the next few weeks (indistinct words) will be most beneficial to the Commission.

PROF KING: Well, I think both. Can I get just a very quick summary because that will help guide where we place our questions?

MR McMULLIN: Yes, sure. So I think - I've got them written in front of me here, I'll be able to send them through (indistinct) more detail but particularly around things like training of educators in universities; that we have seen some really terrific results from high school teachers as well as university teachers through accredited mental health training that is situating the responses and the lived experiences of people with mental health challenges has been a really part of our work.

We've also got a few approaches that we run internally around employees in businesses (indistinct words) organisation which we can touch on if that's something that's of interest to the Productivity Commission.

PROF KING: Yes.

MR McMULLIN: On top of that we really wanted to talk about the - so one of the challenges that came up in the workshop - not the workshop, the discussion online that you guys held a few weeks ago around clear evidence around school programs and there being not a great deal of clear evidence but there are lots programs that are run in high schools around the country and we just wanted to comment on that because a lot of their gold standard research programs - programs that have been backed up by the gold standard researches, (indistinct words) like that, when they're rolled out in the real world can sometimes not have their desired impact in that disengaged young people might struggle to really internalise the (indistinct) from the program and the need for having engaging and exciting programs for young people is a really important thing that we think is an important element of running programs for young people in this basis so that was another element that we wanted to touch on but I'd be happy to take any questions that you have from our summary that we put through to the Commission earlier or I could go through some more detail about some of these things I just raised.

PROF KING: Okay. So I'm going to start off on the first one which is the universities one and - because leading up to our draft report we had a lot of discussion internally about how far we should go with universities and - so we're very interested in more feedback because we didn't - in some ways it's still really quite an open issue in our report. So we see certainly at the school level our approach has to been to say, 'We don't want to duplicate clinical services in schools. We want to make sure schools are effective gateways to community-based services'. Universities we haven't gone there yet and there's internal discussion about it because universities obviously have counselling services. They do offer in a sense clinical services quite explicitly inside particularly the larger universities and so I'd be interested to get your opinion. Is that the way to go or should we be thinking about universities as a gateway as we have with schools and if there's a difference there, why the difference?

The second bit I'd just like to go to is that training of educators. We haven't tried to put a cost on it, we haven't even gone down the path of saying, 'Well, what is the different level training for all the different educators in universities from level A academics who may be dealing with (indistinct) classes to Level E academics who may not see students from one year to the next? But also getting into things like post graduate supervision and so on so I'd be very interested in those two issues. Universities as gateways? Is that something we should do or is it better for them to have internal counselling services? And the training of educators in universities: what sort of range of training do we need there given just the huge range of interactions that occur in tertiary institutions?

MR McMULLIN: Yes, thank you so much for that. So firstly on the universities as gateways. Something that I'd like to upon is Orygen has been around the development of a university mental health framework and I know that a lot of work has been going on with expert groups, so advisors and a lot of discussions around these very points and around how a national mental health strategy can fit into a university and would should happen from a policy perspective as well as an individual university perspective?

But I think the overarching thing for us is that a lot of students that leave schools and schools that have really good structures of support and networks around them in general or even just the structures that are there already, what ends up happening is that a student might go to university on-school or take a gap and then go to university after taking a break but there's a real transition at university and I really think the value of the university setting for discussions around mental health I think is really, really great because of that - really, that transition period for the young people or for anyone else who's going to university, not necessarily young people only, but it can be a real point of transition and points of transition, as has been discussed in this report and other reports around mental health challenges, can be a real instigator of mental health challenges for young people or for other people and I would strongly suggest including looking at universities as gateways mostly because of the real challenges that young people and people in general have in their involvement at universities and I think it could be a good opportunity for us to have those discussions there as well.

PROF KING: Okay.

MR McMULLIN: And further to that on the training of educators, I think some of the structures that we have put in place around training teachers and training educators around mental health has been about situating that experience of people who go through their mental health challenges and how an institution can impact that - positively impact but also negatively impact that and for them to be aware of that involvement and aware of the things that they can do as educators to support the people that are going through their institutions and support themselves as well as their communities as a whole.

I think the educators have a really important role (indistinct words) and our training that we provide for predominantly high school teachers have been around situating that lived experienced speaker at the centre of the program and then making use of that of a workshop scenario to create a space for teachers to start reflecting on their own involvement in their young people that they work with, as well as trying to assess the things that they do to look after their own mental health, because as an educator, that is looking after their own mental health. That shows, in a practical sense, what people can do to look after their own mental health, and also that means that they're pouring from a full cup, is basically the metaphor that I was trying to aim towards.

But yes, they're some of the items on universities or training of educators. Were there any other elements that I didn't touch on there, from your question?

PROF KING: Well, just one more. Start to get into almost, the employment space. The problem is, high school scenario I think probably flows through to say, tutors in particular, level A academics at university, and some lecturing staff. But then when you start getting into say, post-graduate students who get into PhDs - and I'll just state, I used to be Dean of Business at Monash and I didn't last very long, I will say, on the record. But I thought some of the behaviour that institutions tend to take for granted with regards PhD students and their supervisors, masters students and their supervisors.

Do you have anything to say there? It's almost like a workplace, because there seem to be significant issues of bullying that can occur there. But any thoughts about that space?

MR MCMULLIN: Yes. We generally haven't worked with post-graduate students because of our role as a youth mental health organisation; we generally work with undergraduates. But a lot of post-graduates do come along to our programs and we do run some programs with post-graduate students, and I do think - as you have accurately pointed out - there is a role that could be played, and further conversations to take place, to really understand what's going on for post-graduate students at universities, and what sort of pressures they're under. And I think there could be value there.

I am a bit cautious about saying too much more than that; I don't really (indistinct) that space.

PROF KING: Yes, I understand, that's fine.

MR MCMULLIN: But from the people that we have spoken to, they have told us that there is a need for post-graduate students to have more meaningful programs, or more meaningful engagement, with their own mental health, in respect of they and their supervisors, and the organisation as a whole can take, to create a space where people feel safe to seek help if they need, and to have conversations with their colleagues and the people that they work with.

PROF KING: Okay, thanks for that. Julie?

MS ABRAMSON: Ben, it's Julie Abramson. First of all, thank you for all your help and assistance with this inquiry; it's been really appreciated. I wanted to ask you about those group role kids - and we did speak about them in the report - that actually drop out of school and are not in vocational training or going on to uni, and what type of things you could recommend for us in that space. We spoke a bit about outreach, and making sure that at least the Education Department knew where these students were. But really interested in some creative solutions as to how we can re-engage that youth.

MR MCMULLIN: Yes, fantastic. Thanks for that question, Julie.

And I will point to a project that we're working on at the moment, around young people not in education and training, or employment, education or training. And this has been something that we've been working on in New South Wales, predominantly, over the last year, and I think we've learnt a lot out of the work that we have done with the New South Wales Government there, around how to reach out to young people, how to engage them in conversations about their wellbeing and around the things that they're doing to look after their wellbeing, but also look for opportunities for training and for employment and education.

Some approaches that we have taken: we're a peer-led organisation which really centralises the experience of peers. And that has been something that we've really tried to lean into with this, and using the lived experiences of people who share the experiences of the people that we're trying to reach out to; has been a really important step for us to engage those young people.

So in our workshops and in our programs, the lived experience speakers' stories are the real centrepiece of the program, and in the work that we've done with young people in employment, education or training, has been around telling a story of someone who has gone through a period of not engaging in school, not engaging in training, and what they and their community did to take those steps out of that situation for them, and into employment and training opportunities. And so that is something that I would really point to as a great solution to, or a possible solution, for people to look at around making use of the lived experiences of young people.

I could also be really keen to connect you with some of the people in our organisation that are working in that particular project, who might have some more evidence and advice to give around that.

MS ABRAMSON: Thanks, Ben, because we would encourage you. If you can put in a submission to our draft report, that would be really helpful to get some more information about that, because I particularly might direct it to your people. I am particularly interested in how you reached that cohort; so you've talked about the lived experience, but how do you get people to come in your door so that you can connect them with services?

MR MCMULLIN: I don't want to step ahead in case there are some things after the last little while.

MS ABRAMSON: Yes, sure.

MR MCMULLIN: But one of my colleagues was talking to me about this last week, and it has been predominantly through other services that we have connected with young people; I think we have connections with Youth Justice in New South Wales, as well as people in share homes, as well as trying to make connections through the foster care system, and a few different housing institutions that we can connect through, as well as people who have gone to universities or TAFEs or other educational institutions who might've dropped out as well.

They are some of the spaces that we have looked at to include, or to reach these young people not in employment, education, or training. But I will take that advice and put that submission together, with (indistinct).

MS ABRAMSON: Great, thanks, Ben.

MR MCMULLIN: - - - be able to give you a bit more advice on that.

MS ABRAMSON: Thank you.

MR MCMULLIN: Thanks, Julie.

PROF KING: Okay, just one final one from me. Your work with lived experience and using lived experience training, it's really fitting into a pattern that I guess I've seen since our draft report; which is in our draft report, we talk about peer workers and potential for peer workers. But lots of people are now grabbing that and saying, "Ah, well here's where people with lived experience or more formal peer workers can really help out."

So training is one of them. Do you have any other thoughts about where we can really best enable people with lived experience to help others who have mental illness; any thoughts around that?

MR MCMULLIN: Yes, thanks so much for that question. I think that some of the ideas that we have, I think have been hung out in the truck port, especially around the non-clinical settings. For mental health professionals, making those connections with young people with lived experience can be really powerful.

And I think I'd take you also to our overarching theme that we have from our submission, around a community building to increase social inclusion and reduce isolation; and I think that's a really valuable thing that people with lived experiences can share and contribute to this discussion, where the fear or the stigma around reaching out for help with mental health, or talking about their own challenges with mental health, can lead to feelings that you're going to be isolated from the community. And sometimes, that can become a self-fulfilling prophecy.

I think by making use of people with lived experiences to connect with people in more settings and more communities, more opportunities for those stories to be shared, can be a really powerful thing. And I think making use of people with lived experiences and the stories that they can tell about that is a really powerful and forceful tool that can be used to connect young people. I think as has been pointed out in the report, connection with young people is a really important bulwark against mental health challenges, and the worst outcomes that can lead from that.

I would just strongly point the Commission towards the really powerful uses in community-building, in creating behaviour change through the shared lived experiences of young people with mental health challenges; it can be really exciting for increasing health-seeking rates in young people, as well as decreasing some of the stigma that we see across society, both self-stigma, structural stigma, and societal-wide stigma as well.

PROF KING: Anything else? No. In that case, look, thank you very much, Ben, thank you for calling in and joining us, and providing that information; I found it really useful.

MS ABRAMSON: Yes, thanks very much, Ben.

PROF KING: Thanks, Ben, thank you.

MR MCMULLIN: All right, thanks very much. And as I said to you before, I really appreciate the opportunity to connect with this process and really commend you on all your hard work on the draft report, and on the future report that's coming early next year.

MS ABRAMSON: Thanks.

PROF KING: Thank you.

MS ABRAMSON: Thanks, Ben.

PROF KING: Thanks. Thank you, yes, you need to call back in blue jeans and get to the - - -

MS ABRAMSON: We'll just have a five minute.

PROF KING: A five-minute break if anyone wants to jump up and stretch your legs, because we've got to call back into the Melbourne office.
SHORT ADJOURNMENT

PROF KING: If you could state your names and organisation for the transcript, and then if you'd like to make an opening statement?

MS FELTON-TAYLOR: Thank you. I am Leith Felton-Taylor from the Mental Health Community Coalition ACT, and this is my colleague Inge Saris. Straight into the statement?

PROF KING: Yes, please.

MS FELTON-TAYLOR: Yes. Interestingly, I've just come from a mental health services mapping workshop, which has got people from around Australia, which is quite interesting in the context of being here today, I think. We, like many others, welcome your draft report and thank you for the enormous effort that you've put into it, and the wide consultation, and we're very pleased to have the opportunity to contribute today.

We intend to make a submission before the January deadline. We need to consult more broadly with our member organisations; we represent the not-for-profit, non-government community mental health service providers.

So we just wanted to focus on a few key points today. So we felt on our first reading, or what we've been able to read of the report so far - - -

MS ABRAMSON: You haven't read 1235 pages?

MS FELTON-TAYLOR: Sorry.

PROF KING: Like, all three of us have memorised them.

MS FELTON-TAYLOR: But some of the recommendations and the narrative in the report are not commensurate with the extent of reform needed, so we just want to focus on a few of those.

In particular, we thought that the discussion around early intervention and prevention, while recognising that doing that sort of work early in life is very important, and there as a lot of focus on you know, schools and what we can do with that population, we feel like there needs to be more focus and recognition and understanding that early intervention and prevention is important at any stage in a person's life; it's also really important in the first episode of illness; and it's also really important if people become unwell again, because as we know, mental illness is often very episodic.

So I think we feel very strongly that there needs to be a lot more focus on that fuller understanding of early intervention and prevention, and the sort of services that go with that. It really just comes back down to that philosophy of getting the right service at the right time, in the right place.

The second thing that we wanted to focus on is that the gaps in the services which are identified in all sorts of different reports, including this one, won't be sufficiently addressed without a very strong focus on secondary community-based mental health services. One of the things that we see again and again is a lack of deep understanding of the non-government mental health service sector; so there is community-based mental health services that are provided by government, but there is also a very important role of the non-government sector, particularly in providing those psychosocial services that help people stay well, integrate into their communities, make a contribution, while they are recovering.

And these services are very strongly based in a trauma-informed and recovery-oriented focus, and play a very important role in both reducing the costs on the health budget, but also in increasing the productivity of the economy. Because, while you keep people well, they are able to contribute in the best way that they can at that stage of their life, and according to their preferences.

We feel like at the moment, the way the report is, is it is too framed from a clinical viewpoint when it comes to talking about community services, and that there is really a very, very desperate need in our society for hospital alternatives for people who have mental health challenges. The evidence is very strong that people recover best in their communities, rather than in hospital settings. And we draw attention to the comment that the ACT Government made in their submission to this inquiry, where they state that they don't believe that a continuation of the existing policy approach for an improvement in outcomes is inextricably linked to investment in clinical services, is sustainable or evidence-based.

We feel like one of the things that should be looked at as part of this report is investing in a proper understanding of this part of the mental health service landscape, and perhaps also in looking at how it can be properly defined so that we have something like a you know, a national professional association and clear career development pathways, so that we are working towards the most efficient investment of government dollars into keeping people well, and the best outcomes that we can get.

The next thing I wanted to focus on was the social determinants of mental health and wellbeing. Once again, we feel like it's been looked at, but again, it's not been looked at as extensively and deeply as it could. And I guess it ties in very strongly to that previous point: I mean, the not-for-profit psychosocial services are very, very ingrained in that whole social and economic determinants of good mental health and wellbeing.

The example that we would use, like, if you give a person a house without any wraparound services when they're on their recovery journey, it may not work very well; but you give them the house and you have those wraparound services, you look at the person first and the patient second, you are going to get much better outcomes.

Another thing that we think is important in terms of the social determinants is a real critique is needed, I think in all government policy areas, of the unintended impact of some government policies and services on people with mental health challenges.

For example, some of the income support systems such as Newstart, can and do, trap people in poverty and social disadvantage. You know, the difficulty of getting a Disability Support Pension and the small amount that it actually pays can trap people in dependence due to the difficulty and time involved in obtaining it, the risks of losing it, and then if you go into another episodic nature where you need it again, it's not going to respond immediately to your needs.

One of the things that we would like the Commission to consider in its final recommendations is the development of a nationwide wellbeing index; we feel like this would be a very powerful tool for defining and measuring wellbeing; it creates an incentive for governments to invest in and promote better wellbeing; and it's also a very effective way to collect better nationwide data.

There are a couple of key areas where we think the report has not really focused on; one of them is the importance of trauma-informed mental health services. But not just mental health services, but in a wide range of services that people interact with on a daily basis; for example, transport, schools. You could go through, because you know, people who live with trauma can be very accidentally triggered into trauma, so the more that our society understands what trauma is and how to recognise it, and how to respond to it, the better we will all be.

The other thing that we feel is that the actual recovery framework, the recovery focus, is not strong enough in the current report, and we would strongly recommend that that be explored further in the final report. You know, it's the difference between a maintenance model and one that keeps people at some sort of level of wellness, versus one that actually builds people's capacity and ability to be independent and engage with society.

So, thank you.

PROF KING: Thank you for that. There were a few things in there; let me start off on the income support, because I don't know if you had a chance to look at our recommendations on the disability support?

MS FELTON-TAYLOR: No, I haven't, sorry.

PROF KING: Okay, well I won't go down there. But if you get a chance before you put another submission up, I'd be - - -

MS FELTON-TAYLOR: Yes, we do intend to actually look very, very closely at it.

PROF KING: Yes, I understand. Be really keen, because we have tried to address some of the issues that you've said about the cyclical nature of mental illness and the inflexibility of things like the Disability Support Pension.

MS FELTON-TAYLOR: Yes. We often come across people who want to work more, but they won't work more because it puts their pension at risk.

MS ABRAMSON: We're very interested in that, and we had a good, hard look at it. One of the issues was, given that they have to administer you know, a scheme across a whole range of things, how can we build in the flexibility and a responsive system? So any ideas you have, we'd be very interested.

MS FELTON-TAYLOR: We also have the other example of working with people who clearly would be eligible for the Disability Support Pension, but won't apply for it because of the stigma. And I was personally asked to write a letter in support of someone and I found it absolutely abhorrent, what I had to do, because really, I had to write about everything that was not good about this person. And I was told I had to make it as strong as I possibly could, which, given the respect I had for this person, who was clearly intelligent, clearly willing to work but was disabled by their mental illness, I can't put in words how I found having to do something like that.

MS ABRAMSON: Well, it doesn't support the recovery model.

MS FELTON-TAYLOR: No.

PROF KING: Can I just ask about the trauma-informed mental health, or approach to health? The approach you are taking - if I have understood your concept - is very much a society-wide view that there needs to, in a sense, be society level education about issues of trauma, you know, the potential for vicarious trauma and so on.

How do you see that being put in place? And I'll put that with to think of stigma as almost the opposite side of that, because we have a society that's riddled with stigma for mental illness, and we've tried to address some of that; we've talked about stigma-reduction campaigns. In a sense, you're saying we need to go beyond that to get a trauma-informed society; how do you see that working? Do you see it as a staged process, or?

MS FELTON-TAYLOR: I don't think it's something we could achieve overnight. I think that's something that is very incremental, and one of the things that I think would be fantastic if the report could do is, almost sort of present a step-by-step framework for how we get to endpoints like that.

So for example, I know in the ACT, one of the things that we're doing as a peak body is, we're buying trauma-informed training in bulk, and offering it to our member organisations at a discounted rate. Every time we offer it, we end up with a waiting list, so the need is there for that general awareness of what trauma is, and what it's not, and you know, how it flows into people's lives. I am not an expert on trauma; I know there are a lot of people around who are.

The other thing that we are being asked for now is just being trauma-informed is not necessarily enough; we need also to know how to work with trauma. And from what I've been told by some people who are specialists in that area is, there is not enough in that how to work with people with complex trauma or trauma. I think it is like stigma: it will take a long time, and it's just something we've got to start working on, and chip away at it as much that we can.

MS SARIS: And I think peer work will also be very important an area, where you have people with lived experience who can, you know, help other people and make it more acceptable. I mean, my dog is very cute, but he's here for a reason, and that's a very difficult thing for me to decide to take him as well, because I put the spotlight on myself. And a lot of people are very ignorant about why I have a dog, and there's still a little bit of stigma around that, and some places won't let me go into them, even though they have to.

So things like that. There should be a much clearer message, I think, that you know, support dogs are there for a reason and should be just normal, open and accepted kind of stuff. You can see it as a little bit of my own way of making it more acceptable, and people don't usually ask what's wrong with me, but some do and so you kind of have to find a way of not really explaining what it is, but still.

MS FELTON-TAYLOR: And I think, you know, a lot of stigma is based around myths and misunderstanding, so the more we can push appropriate education out into our society, the more it's going to contribute to breaking down stigma. And if people don't recognise trauma and they don't recognise, if they have no knowledge of ways to behave with people that are safe, then you can inadvertently trigger people into trauma or create traumatic experiences for people. So the more we have that understanding, the more it helps people not have so much stigma in the way they view other people. Sorry, that's not a - - -

PROF KING: No - - -

MS FELTON-TAYLOR: It's not a clear strategy, but there are people around who - - -

MS SARIS: Everyone has trauma at some level; just people react differently to it, based on what's happened in their life, and you know, the resilience that they have. So I think normalising it in that way, I think everyone experienced trauma in some way or another, and it's how you deal with it and just make it okay. I think campaigns of RUOK? and allowing people to talk is a first step, but it needs to be going much further, because what happens if someone says, "I'm not okay"?

PROF KING: What happens next, yes.

MS SARIS: Yes. So it kind of takes you - - -

MS FELTON-TAYLOR: And there's a huge voice of lived experience in Australia with huge expertise in this sort of area.

MS ABRAMSON: We've had quite a few people talk to us about trauma-informed policy, so in the context of your submission, you setting out what you think it means and what the policy responses should be would be very helpful for us.

MS FELTON-TAYLOR: Yes, we'll certainly do that.

MS ABRAMSON: I do have a question. You mentioned before, gaps in services, which you said wouldn't be sufficiently addressed unless there was a focus on secondary community-based mental health services; I was wondering if you can unpack that for us, and give us a bit of a roadmap: what would you like to see in that space?

MS FELTON-TAYLOR: Well, for example, one of the things that I've just seen at this mapping workshop, it benchmarked Australian services against gold standards and it showed that there is an 80 per cent gap in the need for community mental health services.

I think it really comes down, fundamentally to that no-wrong-door sort of concept, you know? The right service in the right place, at the right time. In the ACT at the moment, we have people facing waiting lists nearly every time they try to get into these sort of services; we have - - -

MS ABRAMSON: Can I just pinpoint? I think I do know what you mean, but what services are you particularly talking about? Is this residential care in the community, or?

MS FELTON-TAYLOR: It's all the outside-of-hospital services. So they are capacity-building services that help people learn to live in society again, and feel confident to live in society again; they are supported accommodation services; they are services where some people might need 24/7 support in accommodation, not just several hours a day; they are services where people are too sick to receive the support just through Better Access or a GP, but not sick enough to end up in a hospital.

MS ABRAMSON: Go into hospital, yes.

MS FELTON-TAYLOR: And we don't want them to end up in hospital anyway. So they're group-based activities; they're individual activities; they're things where people might be supporting a person to go shopping, write letters.

MS SARIS: Mind dogs.

MS FELTON-TAYLOR: Mind dogs. It's a very big range of services, and one of the things that as a peak body, we struggle with all the time is, that there doesn't seem to be a very good understanding of the range of services and the range of qualifications and skills that are needed to deliver them.

And people seem to fall through the cracks when they're in that middle area, and also when they're in that very, very complex area. And particularly since the advent of the NDIS, which has effectively put downward pressure on wages, it's taken away block-funding, which gave organisations a lot of flexibility on a day-to-day basis to respond to needs; so if there was a crisis, they could respond immediately. Those people, the system at the moment, is not there for them.

Was it just yesterday, and we were instituting a community practice for NDIS support co-ordinators, and the support co-ordinators at that meeting were saying, "We ring service, after service, after service, and they won't take these people. And we know sometimes, it's because they're full, but other times, we don't know why they won't take people." And we've also heard our service providers say to us, "We don't have the money to pay for the required skills to work with people who've got very complex, intense needs." I don't know, does that help?

MS ABRAMSON: It's very helpful. And once again, I know I'm saying, "Oh, could you put that in your submission?"

MS FELTON-TAYLOR: We do, we want to really explore that with our service providers, about you know, how we can flesh that out in our submission in January, yes.

MS ABRAMSON: Because we were very well-aware from the conversations we've had since the release of our report, that we need to look more closely at this.

PROF KING: Just before we move on from that, you did mention also career pathways, just in passing in your opening comments. Would you mind expanding on that?

MS FELTON-TAYLOR: One of the problems that the sector faces is, because the wages it offers are not very competitive with a lot of the other wages, particularly in a town like the ACT, where we've got government here, it's very hard to attract people in, to keep them in, because there's not very far for them to go, you know? Like, people come, get a bit of experience, go off and do something else.

So you know, it probably, in a way, comes down to the bottom line being the money that is allocated to this part of the sector. But we need to look at, you know, when people are coming in young and fresh out of training, that they can aspire to have a career in this sort of area, if that's what they want to do, and still be able to afford to pay their bills and buy a house, and have a reasonable life. People leave because they don't have that.

MS ABRAMSON: I suppose we've looked at one part of the equation, which really was about the length of contracts for the providers; but you're saying it's the workforce as well?

MS FELTON-TAYLOR: It's both.

MS ABRAMSON: I understand.

MS FELTON-TAYLOR: And we also have, you know, again and again, providers who lose workforce because contracts are short; they're not given very much notice about when and if they're going to be renewed; people who are being employed are thinking, "Well, I've got two months' worth of contract left, and I've got an opportunity over here which is for 12 months." So no matter how passionate they are about their work, sometimes it's a choice they just have to make, to move.

MS ABRAMSON: The Productivity Commission has said that on a number of occasions, in a number of reports, so we live in hope, yes.

PROF KING: Harvey, do you haveany questions?

PROF WHITEFORD: No, I think you've covered the couple of questions that I was going to ask, so that's good.

PROF KING: Okay. Just one final one from me. And this is to get this on the record, because one of the things I've become aware of since the draft report is, when you mention the word "recovery-focus" recovery actually means different things in different parts of the system. So the clinical understanding of the word "recovery" seems to be different from the term "recovery" as used by (indistinct) in the community-care sector.

So are you able to just briefly outline for me what you mean by "recovery-focus," what you mean by "recovery"?

MS FELTON-TAYLOR: We don't look at recovery as something that is reached, like you do when you've broken a leg and it's healed and you're able to walk again; we look at recovery as a continuum that sits alongside understanding that mental health is episodic. So it is building people's capacity to live the best life that they can, the life that they choose in the community, with agency and with independence, and with dignity.

So it's not just being discharged from a clinical setting; it's about the ongoing life after that.

MS SARIS: Contributing and completing the goals that people have in recovery is helping people reach any goals that they set themselves.

MS FELTON-TAYLOR: So for example, maybe a support dog is part of that recovery; maybe dipping in and out of services is part of that recovery. One of our service providers has drawn a very lovely map which we refer to as "the golden highway," of somebody sort of walking along a road and there's all these services around here, and the notion that they just pull them in when they need them.

PROF WHITEFORD: But I think we need to make sure that we're very careful in our language, because whenever you start talking about a clinical setting in the recovery, as opposed to stabilisation - and I think we probably weren't particularly clear about - - -

MS FELTON-TAYLOR: Well, one of the bits of work we've got in the ACT is trying to improve the interface between the two parts of the community-care system, so the government provided services and the non-government provided services, so that people who are using those services are not really aware that they're in government or non-government; they're just getting what they need.

PROF KING: Yes, okay. Other questions?

PROF WHITEFORD: No, that's fine.

PROF KING: Thank you very much.

MS FELTON-TAYLOR: Thank you.

MS SARIS: Thank you.

PROF KING: So I'm just going to take a two-minute break.

And if you could just state your name, your affiliation, for the transcript? And then if you've got any opening remarks, we'd like to hear them.

MR BUSH: My name is Bill Bush; I'm President of Families and Friends for Drug Law Reform, and I am appearing with my colleagues Jan Lee and Virginia Hart.

I must say, that having sat here since the beginning of proceedings, I am just so overwhelmed by the open-minded approach you're taking to this really very complex issue, and your probing questions, and gently so. I hope that we don't - or I don't - push you beyond the limits of that wonderful tolerance I have seen.

Our group is Families and Friends for Drug Law Reform, and we were founded in 1995; we have a few hundred members across the country. With a name like that you might ask, what right, what interest, do we have in mental health?

Well, drug dependency, as you would know, is characterised as a mental health disorder under the DSM, as drug abuse is under the ICD diagnostic things. We've had support for families and friends with other mental health conditions; we've been involved with that. Early intervention for mental disorders, crime and drug dependency, involving addressing many of the same risk factors. And subjecting people to the stresses of the criminal justice system is a risk factor for mental illness.

There is high correlation between suicide and substance abuse, and we were all the more surprised that the list of risk factors in Volume 2 does not include substance dependency. In our submission you will see there is US research that's shown that where, for example, with alcohol, the level of suicide is ten times more than the background population; it rises with the illicits until you get poly-drug use, which is an astounding 19 times the background population. But the figures are in our submission. Jan will be able to speak more about her own family experience in this very, very painful area.

So that's why we're interested in mental health, and hence, we've been involved in it. The infringement of drug laws often brings people with mental health conditions into contact with the justice system; arrest, charging, and fining, even without imprisonment, can ruin life's chances. The ACT prison, we argued that the ACT prison was unnecessary, and because prisons have become de facto mental institutions, we argued that with appropriate drug policies that were promoted for example, by the Liberal Chief Minister of the day, we probably wouldn't need an ACT prison.

We were intensely involved for a decade - after we failed in that quest - in relation to the ACT Community Corrections Coalition that sought to influence the operational regime of the prison. And in that context, that is the fruit of it, this health your harmful mental health and the operation regime of a new ACT prison, in which we co-operated very closely with the ACT community. The Coalition has just spoken to (indistinct) and through the coalition that we were involved with.

So there was also, of course, the great report, the great Senate Select Committee on Mental Health that reported in 2005; and I mean, that was a fairly lengthy submission that we put into that. And that, of course, undertaken by the Mental Health Council of Australia, and the Brain and Mind Research Institute, in association with the Human Rights and Equal Opportunity Commission.

And in the same year, we made a submission to that, and that report, memorably, used the memorable phrase that co-occurrence of substance dependency and other mental health issues is the expectation rather than the exception. And you have wonderfully included that quote in the draft report. And at the moment, we're engaged and co-operate with the Canberra Mental Health forum. So that's our engagement.

But what we don't want is another inquiry in a quarter of a century's time hence, looking at the very same issues that the Mental Health Council and the Senate Select Committee ably addressed 15 years ago. And that Mental Health Council inquiry led to the not-for-service report, which is still - it's a compendium of the horror that is involved in the lived experience of families and carers, principally, who are dealing with mental health.

I mean, it's still as relevant now as it was then. And some of the submissions, like the Samaritans group within the Anglicare family, have made that point: that the recommendations of the Senate Select Committee are as relevant now as they were then.

Now, certainly, the Treasurer commissioned you to look at mental health, to come up with an answer to the human and financial crisis represented by our mental health system. But you won't make a lasting, affordable change, unless you do something about the elephant in the room of drug policy represented by co-occurrence or comorbidity; I believe that the phrase co-occurrence is more favoured by consumers and the sector.

Please don't protract the suffering, please don't protract the suffering and waste yours and our time. And please bear in mind that the Treasurer's charge that you should address the negative impact of comorbidity on economic participation and productivity in Australia, hence which has a potential to impact incomes, living standards, social engagement and connectedness, which are very much involved, brought into play, when you're dealing with clients with complex needs, as you are where there is comorbidity with substance abuse and other mental health issues.

So there's been enough of flick passing the nettle to service providers to deal with the problem. Experience is showing that even with the buckets of money mental health and AAD sector service providers cannot be expected to resolve a situation riven by tension between a caring health-centred approach on the one hand, counterbalanced by an alienating and stigmatising one, underpinned by the punishing ethos of the criminal law on the other.

How do you treat a person who, at one and the same time, should be processed as a patient and as a criminal? The policy response we seek is treatment that is effective, accessible and non-stigmatising. There are submissions before you that effective treatments exist; the problem is that that treatment is not accessible, and the treatment that exists is stigmatising, courtesy of the characterisation of the patients as criminals.

It creates - to refer to some of the other evidence we've heard - this is a huge factor in the disintegrated nature of the nature of the systems that are trying to deal with these people, and promotion of a sense of worthlessness; worthlessness by the people who are in that position, by their families and those that surround them. So your draft report recognises that policy adjustment in fields like housing, which are, on their face, unrelated to mental health, may nevertheless improve the situation; in fact, there has been so much discussion about the psychosocial impacts.

Now, all of them potentially involve leveraging matters that are outside the narrowly-focused mental health field. And I feel that you are really struggling with how you can draw a line between those sort of a helpful engagement with these, but not sort of open-endedly redesign the housing policy in this country, the criminal law policy in this country, or indeed, Australian society as you said in one of the cases.

It is therefore inconsistent to exclude consideration of the even more cogent factor of drug policy in this mix. The evidence referred to in our submission could improve mental health, and do so more cheaply and quickly than other policy options that you know, you have been considering. To do so is no less relevant to improving mental health than consideration of decriminalisation was to the Queensland Productivity Commission reference on imprisonment and recidivism, which you know referred to the possibility of decriminalisation.

But there is this question of suicide, and I just invite Jan to say a few words on that.

MS LEE: I have three daughters; two were older than the younger one, and the middle one has died. The middle one was a child with a lot of potential, but when she hit adolescence, she struggled because all of a sudden, she had to put in an effort to do well at school; and we're all familiar with that. And so instead of putting in the effort, and because I guess there were family issues - her father and I had separated and so on - she just decided that she would experiment with drugs.

And that, of course, didn't improve the going through adolescence; it made it worse. She failed at school; and failed at various other attempts at part-time employment and so on; denied that she was taking drugs, but we all knew that she was; and the drug use exacerbated her existing problems. So just the issues of going through adolescence with a broken family behind her and so on, were compounded by taking drugs.

She took up prostitution to support the drug habit; it didn't really help the mental issues, so finally, she decided that everything was hopeless. She and I talked about it a bit, and she said you know, "I'm feeling hopeless but I won't do anything," and I said, "Look," you know, "I don't think anybody has to live for somebody else. If you're living just for me, you don't have to do that." So eventually, she committed suicide: she hooked up a hose to her boyfriend's car and turned on the engine, and that was that.

Her elder sister had experimented a little bit with drugs, but I think under the influence of the younger sister, like, "Come on [eldest daughter], have a go. It's fun." She fortunately didn't succumb, and went on to get a successful degree in veterinary science, and had a relationship which eventually failed, and she just sunk into deep depression; and at that stage, she also experimented a bit with drugs and almost died.

But she pulled out of that and is now working successfully and having, I think, a fairly happy life. So that you know, her drug use I think possibly, initially - well, it could've been depression because she had to move away from home to study, and taking drugs alleviated the feelings of loneliness and depression and so on.

So there is a mental illness component that starts drug use, and I think it can be triggered at adolescence or by other things. And then taking drugs is a sort of downward spiral, very often; for some people, they are more inclined to become addicted than others. And then once you get into that spiral, then you become even more mentally ill. And [middle daughter] kept a very comprehensive diary, and it was quite clear that she thought that she'd actually ruined her mind, that she was hallucinating, she was no longer the person she used to be, so the drugs had actually caused an extra sort of mental illness load on her.

So there is a huge correlation between using illicit drugs, or any sort of opiates I guess, and mental illness. And there was nowhere much for her to go for help, because she was taking drugs, she was just always treated fairly robustly in hospitals and so on, when she ended up there; so it wasn't an ongoing treatment, there was no sort of rehabilitation offered or anything. I'm talking about the late-1990s, there wasn't so much information about drug abuse and what you could do to stop it then, so I felt powerless to help; I did seek advice, but there was very little available, so I lacked support to support her.

Yes, I think I'd just like to reiterate Phil's concerns that there is a huge correlation between mental illness and using opiates and other drugs, and some of them are illicit, and some of them are prescribed; so think that's an issue that has to be addressed in this inquiry.

MS ABRAMSON: So thank you for so openly sharing your story, which would not be an easy thing to do. What type of interventions do you think would've made a difference for your middle daughter's life?

MS LEE: I think if I had had enough information to recognise that I could intervene early, and get her into some sort of establishment that would offer constructive care, rather than judgemental care, it might've helped. It might not have; in fact, her elder sister said, "I don't think anything would've helped [middle daughter], really," because she really was a fairly strong-minded person, and she always liked to take risks and sort of work on the edge of things; so it might not have helped, but I really didn't have enough information.

The younger daughter has also suffered from anxiety and depression due to the circumstances of her home: her father used to work for the Productivity Commission, strangely enough, but he took up farming and farming went bad, and he suffered from depression and anxiety as well. But he never talked about it; he just started drinking.

So that sort of gave [youngest daughter] a fairly bad home life. I was supporting the family by working, so she felt unsupported by me, and certainly not supported by her father, who was desperate himself but wouldn't talk about it. But she has said, "I probably would've turned to drugs, but based on [middle daughter’s] experience, that was the last thing I was going to do." And she ended up on a disability pension for a couple of years because of anxiety and depression; sort of locked herself away in the home and didn't come out.

And again, I didn't really know what to do. I did seek psychiatric help, and help from psychologists and so on. She found quite often talking to psychologists was a bit unrewarding, because she's an intelligent child; she worked it all out for herself anyway. So she found a difficulty finding somebody with whom she could empathise, who felt they really understood her. One psychiatrist did, so that was really quite helpful.

But yes, so just the lack -I mean, there was support, but it wasn't sufficient. She eventually sorted it out for herself, with cognitive therapy and so on. And people were quite admiring of the way she has actually sort of got through it and is now being successful. But I know she still lives on an edge, because people who have had mental health issues always do.

So it's a subject that is very dear to my heart, of course. But you know, probably many people in this room can empathise with that; it's just prevalent, and I think it's a societal problem, with [youngest daughter] particularly: she didn't know how to socialise. What would've helped her was a sort of fully functioning society where she could've gone and joined groups, and got help and felt useful. It just wasn't there.

MS ABRAMSON: What do you think about the access to services? And I appreciate you're probably talking a little bit about the historic past, but probably not a long time.

MS LEE: No, not totally, no.

MS ABRAMSON: Yes. Do you think that the availability of access to services has improved at all, like, where you go for information? Because we've had anti-stigma campaigns and you know, RUOK?; those type of things.

MS LEE: I think so. I think it would now know - or she certainly knows where to go and find it.

MS ABRAMSON: Yes.

MS LEE: Because she's done a lot of the research herself. And she's working in mental health as well, so yes, I would now know where to go. But I don't know whether everybody in our society does.

MS ABRAMSON: Yes, I understand that.

MR BUSH: Well, perhaps I could come in here? I am, I suppose, a volunteer supporter and on the Family Drug Support phone line; I've been on it for about 20 years and I think I've counted up, I estimate, about a thousand calls I've taken in my sort of moderating thing. But that was founded by Tony Trimmingham in 1997 I think, and as he says, there was just nothing at that stage.

So there is a lot; there are now - each state government has an alcohol and drug information line that does this, and these are linked-in with Nightline and things like this. And there is Parentline in some states. And we refer particular sort of calls to these other things, when they do come up.

But it's this pervasive stigma that comes in as a result of the illegality that's involved; impacts everyone in the mix, including the service providers. And there is a very, very, judgemental attitude that I can tell you stories about in relation to people I've been supporting, who have been sort of discharged from the drug and alcohol service here in the ACT on a Sunday. No-one has been rung-up to support that person.

And this person has huge difficulty in engaging with services and he virtually sleeps all day, gets up about 4 o'clock; he's got an hour to access services before they close down, and then gets very angry because you know, they're not there for him. So he has real mental health issues that really impede the person, and he has lost pretty much all faith in the system, all faith in himself; there is nothing that he feels he can connect to, and virtually nothing worth living.

Almost every time I speak to him, he talks of ending his own life in some way or other, and sometimes it's pretty precise. And many times, his desperate parents have rung the CAT team to seek help, and the CAT team doesn't come out; the police come out. And as my friend tells it, you know, he refers to these as "welfare visits" you know? And to get into the flat that he had - until he was evicted from it, because he was a hoarder and it was a fire danger.

This combination of completely tight bundle of problems that no-one - I haven't been able to untangle, and the system doesn't untangle. He was kicked out by one service provider; I think he kicked a door and damaged it a bit, and he was out. But another time he was kicked out after having got courage to get into a detox, because his manner was passive-aggressive. Now, I'm sorry for any people who are particularly sensitive, but a nurse or a worker in an environment where people with roaring addictions can't have a bit of latitude about some of the language that they may use - no question of violence or anything like that - I mean, you know, I just raise that as a big question.

It's just another one of the barriers that the system and the illegality creates, and the absence of services that are able to adequately engage with these very hard to engage people.

MS ABRAMSON: Mr Bush, we have made some comments around aspects of what you're talking about. I understand the bigger picture that you're talking about. So we have said that we would like more support for places, the frontline in dealing with people with mental health.

We've also, as I think you've noted, looked in the prison system; bearing in mind, this is a big inquiry and the states control the justice system. But it did appear to us that all of the states were putting an effort into diversion programs, so trying to take people at the stage where they interact with the justice system and alter their path of going into incarceration. So at least we saw that there were a number of programs which were operating.

So those are the kind of - and also the other thing I'd say is in terms of the tenancy issue that you raised I'm sure we have, and I'll look at the stuff here, I'm sure we put something in our report about saying that really public housing they needed to look at the circumstances where people might've had some of the issues that you're talking about, because it was quite stark for us that somebody could have an episode, go in to hospital, came out to homelessness because they've said to have breached their lease.

PROF KING: Public housing, yes.

MS LEE: So we we're seized of that.

PROF KING: The other thing, and I'd like your opinion on understanding the policy side, but on the service side, we did also state that our preference was that whatever the regional commissioning approach is, and we put a couple of alternatives, is that the alcohol and drug services and the mental health services are the moneys brought together and they are funded through those commissioning bodies. So would you see that as a step at least in the right direction?

MR BUSH: Well, I think money is - I've often thought that often the problem with illicit drugs is not the drugs and the addiction and dependency it involves, the root cause of it is the money that sort of, you know, that drives the system, and I, sort of - now, I'm a bit hesitant to say this, and this is on the public record, but there is a competition for the dollar between the drug and alcohol services and as you say in the report they're generally regarded as the poor cousin. They have been traditionally as the poor cousin on the mental health system, and this is coming to the fore at the moment in the ACT with the establishment of a drug court.

Now, wonderful, but there will - the concern of the service providers here is that the possibility of mandatory treatment ordered by a drug court will potentially displace the voluntary patients who want to come in, and since it set - it's not as bad - the situation is not as bad as in Mental Health where it's 80 per cent at least there's at least a 50 per cent shortage of spaces per alcohol and drug treatment in the country. So, you know, do you park the ambulance - the old story, do you park the ambulance at the bottom of the cliff or do you build a fence at the top of the cliff? And, you know, the drug court it's therapeutic jurisprudence is the term that these diversion programs and things like this, they are certainly better than the harsh imprisonment undoubtedly but nevertheless the door to it is controlled by the criminal law system and the ultimate guarantor of all these symptoms is the criminal law. I mean, if a diversion thing - if the person doesn't keep up the regime of drug tests and doing whatever the conditions are that have been sent to them, then will potentially be back into the - so, it's the Damocles sword that hangs over them all the time, they are still criminals.

So, yes, it's better, it's much better and there are studies that show - comparing classic study with showing and comparing South Australia, which was the first to move to this expiation notice for cannabis compared to Western Australia which at the time hadn't had that one and there were far better outcomes in relation to keeping employment and relationships and general integration into society in the South Australian system than there were people who went through the traditional criminal law one which still operated at that stage in Western Australia, so, yes, it's better. It's better, but it's still - it's far from perfect.

PROF KING: Thank you very much for that. That was really very useful this morning. Thank you for doing that, and thank you so much for telling us your story. It's not easy.

MR BUSH: I perhaps would say that if you have a chance to listen to a film that's been put together recently called Half a Million Steps, and it's the story about the difficulty of someone, a single mum in Dubbo, trying to access appropriate treatment for her circumstances. The closest available treatment was in Sydney, half a million steps away, and it's a relay from Dubbo to Sydney, and interviewing with no end of people with all manner of conditions, mental health and other - and it's just - it's a moving, warm thing, and it gives very much a human face to the sort of thing.

PROF KING: What is that if you google or YouTube or somewhere else?

MR BUSH: No, no, it's - no, I can refer you - it will eventually be on the web, on YouTube but it isn't yet. But I will happily pass the - - -

MS ABRAMSON: That would be great. Thank you.

MR BUSH: - - -links to you.

MS ABRAMSON: And thank you for appearing.

MR BUSH: Yes, okay.

MS LEE: Thank you.

MR BUSH: Thanks.

PROF KING: Thank you. Nathan? Thank you. Welcome, Nathan. If you can state your name for the transcript and just your organisation, and then if you've got any opening comments that you'd like to make please do.

MR DE TOURETTES: Sure. Thank you for having me. So, I'm Nathan de Tourette from Develop Daily, and we're a clinical counselling service. So thanks for the draft report and the work that you've done so far. The draft changes that, you know, are there at the moment I do agree with a lot of them, and a lot of things that will create change for our consumers that use the services that are offered in our communities.

So just a couple of things that I wanted to touch on was - and I think some people here today have already touched on them, is around consumers not having their needs met in low intensity services through no participation. So I think from that point of view, you know, for me it's going back to the basics which I don't really think the report, like, kind of goes into much detail, and it's all this bigger picture stuff but with that it's really much going back into the basics, and it kind of leads onto, you know, the connection that I've made with the missing middle as well. So, you know, if people aren't getting their needs met at lower intensities they're only going to receive great deterioration in their current situation. If that's not done by - like, due within - if that's not done through informed practice at the very beginning and that deterioration then worsens well, they're only going to put more pressure on the acute and hospital systems. I'm pretty sure that we could all appreciate that.

So the thing is, is that when it comes to, you know, trauma informed care, I think from a policy point of view is that we need - I think it needs to be much more inclusive, and that's all professional roles, need to be much more inclusive across all the policies. So this is from things from, you know, who mental health professionals are to the awards and the rates and pay structures and things like that, employment conditions, because I kind of feel it's a little bit disjointed across them, so in some of those documents there's some professional roles stated, and more the classical ones, but not the other ones. And if we're moving towards a system where we're going to have lived experience and peer work and things like that everyone needs to be much more included in those documents, and then kind of working down, because from a code of ethics point of view we're all there to improve a quality of life in some form for whatever the person that we're working with. We're there to service the people that we work with.

So getting back to basics on that and getting that really kind of clear from the word go is I kind of feel that the language that's used in those documents that I've read over the last half a decade it's kind of really not clear enough that we're there to service the consumers that attend our services. For example, as other people have spoken about what does trauma informed look like the Blue Knot Foundation, and when it comes to the societal issue, The Blue Knot Foundation already have documents written for employment, for the general public, and in my day job, so this is outside of Develop Daily in the way back service and community services, you know, there's this need there that people need or are looking to, you know, have a meeting with their workplace or have a meeting with, you know, their housing situation and, you know, to keep it trauma in formed, but they don't know what it looks like, so I'm very much going through these documents and skilling people on how to set up a trauma informed space. So in our professional training we are all - we all have those skills and in suicide prevention, which is what the way back serves, a lot of our work in the first three months post hospital is about skilling people to be able to even approach these sorts of issues that they're having.

So if that could be done at the very start, you know, it would take the pressure off the system because their needs would be met. So as the people before me share a lovely lived experience, and I thank you for sharing that, but working with that story as opposed to what the professional is thinking, you know, I think that's kind of where we go wrong as professionals in a sense. And as far as, you know, picking up and creating societal changes there was also talked about earlier around, you know, is trauma informed, is a stepped thing or is it, kind of, you know, done in bulk, and the thing is, is that I was reading through the reports and, you know, to put someone - put a wellbeing practitioner in a school, I'm not sure of the exact term of that, but it was adding another role into a teacher's job, you know, the school system is so overwhelmed as it is, you know, so having it in the employment as a mandatory thing just like a first aid or a mental health first aid as currently, or working with vulnerable people check, having that at least when people then attend their job or they have a change of job, you know, they would be sitting and understanding and responding to the trauma workshop, the two day workshop that's been run here in the ACT that has, you know, overwhelming waiting lists.

So kind of updating things on that kind of level what it actually would like to day-to-day or week-to-week for people as opposed to this big picture, because I kind of feel like it's not really - we're all talking about this big picture stuff today but it's not really the - we lose sight of the little things.

MS ABRAMSON: I would - so I just want to pick up the point about wellbeing teacher in schools because - - -

MR DE TOURETTES: Yes.

MS ABRAMSON: - - -I think what was clear to us is that the schools have these issues to deal with already. So the classroom teacher is already having to deal with those types of issues. So we had never seen it as imposing an additional requirement on teachers, rather there would be someone in the school, depending on the size of the school, that would have responsibility overall, so the classroom teacher would be able to go to that person who had teaching experience, which for us seemed a really important part of the puzzle, and then they would provide the assistance and the referral, as Steven said before, to other services. So we'd never characterised it as saying to the teacher in the classroom, "Here you are, here's some additional", it was rather the school saying to us, "We are overwhelmed with the number of programs that are out there. We're not quite sure what we should be doing in this space", and it was to provide that assistance.

MR DE TOURETTES: Yes, I guess that maybe it's just the language that was used in the writing of that which made me feel like it was an additional role on the schools.

PROF KING: On the teachers, yes.

MR DE TOURETTES: Yes. So it possibly could've just been how I interpreted it and really - - -

MS ABRAMSON: It's not a criticism.

PROF KING: Because we need to be clear ourselves.

MR DE TOURETTES: Yes, yes, maybe. Yes be really clear around that and - because it does read as an additional role as opposed to a role that's already happening.

PROF KING: Yes.

MR DE TOURETTES: So - yes.

PROF KING: Can I - from a slightly different path, a number of people today have mentioned the importance of those with lived experience participating with a - as formal peer workers or otherwise as part of service provision as helping people who need help for their mental health condition. And you mentioned that as well, and I suspect we have been, you know, to a high level, sort of said, "Oh, yes, this is important", and we need to make sure that there are appropriate career paths and things like that without actually getting into the examples. Where do you see people with lived experience, just from your basis, where do you see them as being most important in the system? Where do you say, "Oh, but if we only had the funding to be able to have people with lived experience here this would make a real difference"?

MR DE TOURETTES: For me it would be in service evaluation.

PROF KING: Okay.

MR DE TOURETTES: And then off the back of that evaluation - - -

MS ABRAMSON: Could you unpack that a little bit for us?

PROF KING: Yes.

MS ABRAMSON: What you mean.

MR DE TOURETTES: Okay. So, you know, there's - getting feedback from a participant is a one-to-one direct link to the service that they're attending or the service that I provide. You know, having - to be able to make the service better so I have to change my behaviours on how to cater for the people that I'm serving, they're the best people that I can draw upon to - you know, it could be a change in assessment or it could be a way they use a particular therapy or - - -

PROF KING: Yes.

MR DE TOURETTES: - - -things like that that kind of really kind of - it connects to their story. So for example, you know, when it comes to simple things like organising a consultation, you know, I kind of - with a few - for what's important to people is that people need to be reliable, you know, to build trust, even before they step inside the counselling room or the service room, or, you know, the service of their participation. Reliability is - you know, if you were to - it's also the way that - I guess it's like phone manner and things like that or if you're predominantly a texter or you use technology through softwares and things like that to kind of say - it's got to come across in like a warm kind of way.

PROF KING: Yes.

MR DE TOURETTES: A way that he goes, "Okay, I'm going to sit here and listen to you". For example, you know, when it comes to going back onto the assessment type of things not every assessment will fit the person that I work with. You know, that's basically their situation will be reflected on that as basically - that' s not necessarily a direct thing so, for example, if someone wouldn't want to participate in that assessment, and assessment is a big part of gathering outcomes, well, maybe there needs to be a range of assessments.

PROF KING: An alternative?

MR DE TOURETTES: An alternative but also to - maybe one that's more tied to a particular therapy, you know what I mean? So, for example, a therapy that we use is resource therapy, that can work with a whole range of things, so to - instead of just using something like the Kessler 10 plus which is an anxiety and depression - as those are the two, you know - - -

PROF KING: Common.

MR DE TOURETTES: - - -common, most common.

PROF KING: Yes.

MR DE TOURETTES: For example, with the feedback that we've got we'll be looking to use the - what was it called - the - AMU developed it last year - which has a psycho-social element to it. So it doesn't only ask those, you know, the 10 questions around anxiety and depression, but it also then goes into the psycho-social things, so, you know, "How often have you, you know, had connections with your friends, family?"

PROF KING: Yes.

MR DE TOURETTES: You know, those sorts of things as well off the back of that to give us a bit of a clear picture over a five point scale.

PROF KING: Yes.

MR DE TOURETTES: So, there's - you know, and there's a range of assessments that you can use. So, for example, you know, in suicide prevention, you know, some people just literally aren't in the space to cop an assessment on the first day, so as a part of, you know, setting up a treatment plan, which has also been covered in the report, services having the - there's a big gap between what services need to report on and is the person ready to receive that assessment. And clearing up - I guess the lived experience would be really useful in clearing up - - -

PROF KING: So it's really - - -

MR DE TOURETTES: - - -that gap if that makes sense.

PROF KING: Yes. So I guess what you're doing, all the same, which is I think is really important, is we've been very aware of - we want a consumer focused system which means that there has to be the outcome measurement and outcomes are only meaningful from a consumer perspective. What you're really saying is that's part of the story, but what we then need to make sure is that that loop is there so that the outcomes that the consumer experience is then fed back in to the treatment to the program to make sure that it's then being updated continuously so that rather than just hearing, "okay, well, that didn't work", but I guess we just continue doing what we've always done because that's what we've always done".

MR DE TOURETTES: Yes.

PROF KING: But making sure that you get that feedback in there.

MR DE TOURETTES: Yes.

PROF KING: I guess we tried to do that at a very high level rather than in a sense that that - almost service provider by service provider.

MR DE TOURETTES: Yes. And so, you know, getting it down from the bigger picture down to an everyday experience is what really matters for the consumer, because if - and I was also looking through the Medicare benefit scheme and, you know, on average 4.6 sessions are attended out of 10.

PROF KING: Yes, perhaps the better accessed sessions. Yes.

MR DE TOURETTES: Yes, yes, so, you know, having such low engagement - well, it is a low engagement rate, and, you know, if people are feeling like that they're valued, if people are feeling like that that service is making a difference in their life, that they will more likely come back. And so it's kind of setting up, you know, a different type of revolving door, so to speak, and our job is to make sure that we don't have a job at the end of the day, because we're here to be - you know, we're health professionals as a broader umbrella term.

PROF KING: Yes.

MR DE TOURETTES: So, you know, if we were - if that was the case and that was kind of mandatory of every service to have a lived experience component and brought into that especially in evaluation and implementing even just, you know, cross-checking. If there is a new assessment tool that was going to come in, you know, run it by your lived experience or your peer work - - -

PROF KING: Group. Yes.

MR DE TOURETTES: - - -group or personnel, and get their thoughts because that's going to be much closer compared to what I think on my own. You know, even after all the years of studying and everything else and continued learning.

MS ABRAMSON: It would be really helpful for us, and I'm sure you're time pressed, and you've come today to give us evidence, if you could have sort of a submission on how you think some of those things would play out. It doesn't have to be a long submission, just what you just talked about now, "Well, in my clinical practice this is how I would have a person with lived experience involved", so even if it's just a page. That would be really helpful for us.

PROF KING: Yes, because it helps bring us from that high level back - - -

MS ABRAMSON: Yes that's right.

PROF KING: - - -through the practical every day - - -

MR DE TOURETTES: Yes.

PROF KING: Yes, okay.

MS ABRAMSON: And it wouldn't be unusual for us in our final report to be much more explicit. In a draft report we've kind of got the ideas out there, and it's exactly why we have this process, because people like you come to us and say, "Well, actually, this is what is the type of detail that you need to think about".

MR DE TOURETTES: Yes. Yes, okay. And just as another point, I understand that suicide prevention is a major concern across the world and especially here in Australia and more so here in Canberra. You know, just around the education of that I kind of - coming through the university systems and then, you know, attending other things, other institutions and courses and whatnot what to do, you know in every health professional that says, we'll engage with suicidal consumers at some point in time. Even though suicide prevention is becoming its own kind of area - - -

MS ABRAMSON: Discipline.

MR DE TOURETTES: Discipline. It's currently - there's not much teaching going on in that, so I'd really kind of like to, you know, have that - kind of unpack that out as well, because there's so many things that practitioners can do to ensure or help promote safety and that even comes right back down to the confidentiality requirements that we do have and breaching that if there are safety concerns. But, like, I feel that there's one question that is really useful is, you know, if someone does - you know, when you're working with someone and you're working through what's concerning for them there's always going to be an element of feeling unsafe, and it could be that edge that other people referred to today. And that question is, you know, when those things come up it's, like, you know especially at the end of that session, you know, where are you going to feel safe.

PROF KING: Yes.

MR DE TOURETTES: And kind of having a bit of a - like, then organising a bit of a plan around that as opposed to, "There's a safety concern, okay, we need to call the HAART team here in Canberra or the Mental Health Line in New South Wales or - I kind of feel like that there is a really workable space there to ensure to keep people safe and then obviously, you know, if they disclose that there's a location and a means, well, then obviously you're going to then take - - -

PROF KING: Yes, take it further.

MR DE TOURETTES: - - -the appropriate action.

PROF KING: Yes.

MR DE TOURETTES: But, you know, just even - you know, if they do disclose safety concerns I feel like there's much more wiggle room than what society thinks in amongst that, so that would also be good to be unpacked as well.

PROF KING: No questions there?

PROF WHITEFORD: No, it's all good. Thank you.

MS ABRAMSON: Thank you so much.

PROF KING: Thank you very much.

MR DE TOURETTES: No worries.

MS ABRAMSON: Thank you.

PROF KING: So, Terry, if you'd be able to just state your name and background for the transcript, and if you want to make any opening points, please do.

MR DE LUCA: Thank you very much. I'd just like to say thanks for the opportunity to come here and express myself and my concerns and I'm sure something really positive will come out of this experience for both of us.

PROF KING: Fantastic.

MR DE LUCA: Thank you.

PROF KING: So just name for the transcript.

MR DE LUCA: Yes, my name is Terry De Luca. Is that okay?

PROF KING: Please, yes. It's more so that we can from the transcript and recognise voices and so on.

MR DE LUCA: I have a Masters in counselling and a Masters in Educational Leadership, various diplomas and a Graduate Certificate in Human Resource Management. I have been doing part-time counselling since 2012 and have accumulated 40 years in high school teaching and administration. My main focus here is to examine the appropriation of counsellors and the importance of counsellors improving mental health in our community. Forgive any generalisations but because this is only brief I can't really be super-specific.

Just the broad base of mental health issues and how counsellors service these: mental health and mental illnesses are commonly confused. The increase of mental health programs should help in alleviating some of the ongoing impact of mental illness. Some counsellors are suitably qualified to manage some mental illnesses such as anxiety and depression, trauma and stress. Some forms of depression may need medication for management, but many times maybe an inappropriate therapy.

There may be large numbers of people who find the current waiting list and funding arrangements beyond their capacity to assess. As counselling is an intensely personal, interpersonal process some clients need to bond with their counsellor before therapy begins. This means that there can be counsellor hopping, which can be difficult for the client, also expensive and prohibitive according to the Black Dog Institute which was 2014 statistics, as you're well aware, so I won't really need to outline that but there are quite a lot of people who are suffering depression, anxiety and substance abuse, so I'll just sort of move on. We're not here to preach to the converted.

The counsellors are very good at first responders to mental health or mental illness issues. They are trained to recognise their limitations and refer on more complex cases, and you can refer to the Australian Counsellors' Association Code of Ethics which I adhere to. Counsellors share many therapeutic approaches that psychologists use especially cognitive based and mindfulness therapies.

University training requirements and quality control of counsellors: many counsellors have completed Post-graduate Diplomas and Masters and in some cases Doctorates. This level of critical thinking, research based learning, critical reflection, and engagement with higher or rethinking should be considered in funding for counsellors. Counsellors in private practice or working in specific focused organisations are not in the scheme of things well paid, and I think that came out with the previous talker that it often attracts people who are really committed to that sort of thing rather than people who are looking to live the high life, and this limits the attractiveness to the profession.

Counsellors are a dedicated group attracted by the interpersonal aspects rather than other models such as reductionistic experimental models favoured by the Australian Psychological Society. Compared to a psychologist the earning capacity of counsellors is much more limited.

Now, because I've had a lot of experience in schools I just wanted to make you aware of some of the issues that are faced and they've also come up already. If I did not have counselling skills and qualifications I would not have survived as a teacher, okay. I've been in the professional 41 years, but without that I would've walked away, but because I have those skills it's made the profession for me a much more viable and enjoyable process and I'd hate to say this, but I think I'm a really good teacher and I'm highly respected in my profession.

With 41 years' experience in teaching and pastoral care positions I've seen a growing awareness of the need for pastoral structures to enhance teaching and learning, and part of the productivity in schools is that really what we mean to do in schools is improve teaching and learning, so that is a productive process, so we want our kids to come out who are engaged in the learning process and who embraced lifelong learning and that's the ideal but we certainly need a lot more funding for that to come and I'll talk about that in a minute.

The ABS puts the age range from 14 to 18. I think, and my research is around 25 per cent of the population fits in that school-aged demographic. So over the last decade there's been an introduction of IEPs, which are individualised educational plans, and some schools in Canberra have at least 25 per cent of students on this, I won't name the schools, indicating some form of learning disability.

It would not be too outrageous to say that 1.5 million students currently need some specialised assistance with learning. Of these some would have mental health issues which puts considerable stress on school resources. There is now a growing body of research to show how mental health and wellbeing issues is having a significant impact on both teaching and learning outcomes and teacher wellbeing and student wellbeing. So in other words if you want people to embrace learning they have to sort of get rid of a lot of baggage because they're bringing baggage into the school and how do you teach someone who is, you know, very distressed or parents are splitting up, you know, a whole range of personal issues. Only the kids with really severe issues get managed, but there are a lot of kids that fall through the cracks.

The future of developing a quality workplace and its impact on the counselling profession: as a counsellor I have had to deal with clients who are having difficulty adapting to their work environment which has caused them anxiety and stress. Having post-graduate qualifications in human recourse management I have become sensitised to the significant issues. As you are aware that a happy work life leads to greater productivity and the opposite is true, so if you're not happy in your workplace you take time off and someone has to do your work which puts more stress on them and you haven't really resolved the issue of what needs to be resolved. For example, Canberra is predominantly a tertiary culture and staff are well-educated, but many people are dissatisfied and maybe that dissatisfaction comes from they're overqualified for the work they do. But I won't really go into what I think about that now, but it can lead to mild depression if you're not happy in your job.

This is a significant mental health issue and counselling is a suitable profession for this problem, so in other words that what I'm saying is that counsellors can deal with a whole range of mental health issues that may not really deal with specific mental illnesses. Problems that were often overflow into the domestic arena which needs to be addressed, so I think, you know, if we want to improve productivity we really have to address this issue and not only for the individual but because we live in a community and we live in families if we don't deal with these personal issues then other people become affected by them.

In conclusion, in this age of measurement and keeping track of finances which I'm sure you're very concerned about - - -

MS ABRAMSON: Yes.

MR DE LUCA: - - -it stands to reason that by broadening the Medicare system, you know, or establishing an alternative model it doesn't have to go through Medicare, that's just the current system, to include counselling services the government has a better opportunity to keep track of what is occurring. So what I'm saying is that if you were able to put counsellors on a paid system of some sort you're actually - you're gathering data from that. They're telling you what they're doing, what services they're providing and it's providing feedback as to what's happening out there in the community, so I think it's a really important point that I wanted to make that you may not have considered.

PROF KING: Yes, okay.

MR DE LUCA: And this also, by having counsellors put on this system it also causes accountability, so that counsellors have to measure up to whatever standards the system requires. So counsellors are - as a counsellor I am required to attend supervision on a regular basis. It's part of my professional association requirements. I have to attend in-services. I have to accrue so many hours per year of in-servicing to get my membership continued, and so I think even at this point in time it's a well-regulated industry and I would have to say it's more regulated than teaching is, as an end point.

PROF KING: I want to follow up some issues particularly on the school side that you touched on.

MR DE LUCA: Okay.

PROF KING: Because I'm very interested in that but perhaps I'll go first and then - I'm not sure if you've had a chance to look at our recommended approach for schools and - - -

MR DE LUCA: I did have a brief look, yes.

PROF KING: Yes, because our aim is to have schools as an effective gateway rather than to have counselling services in the school. So our view is if you've got an effective community - services in the community you don't need to replicate them in the school.

MR DE LUCA: Can I interrupt?

PROF KING: Please.

MR DE LUCA: Yes. I think - - -

PROF KING: Yes, so I was very keen on getting your feedback on that, because you're well-placed.

MR DE LUCA: That's a good idea but I don't think it's practical in terms of what's happening in schools is that schools usually have a psychologist and, like, I can only talk about the ACT, depending in the size of the school you get a psychologist for the number of kids you have in the school so if you've got 1000 kids you might get two psychologists.

Now, a lot of their time is spent on assessment and, you know, as you know, principals, you've got a lot of kids that have learning difficulties so a lot of their time - they don't have the time to do the counselling, right, so if the kid's just sort of, you know, 'The dog died and I need someone to talk to' they have to go along to a psychologist who's more useful in terms of saying that a kid might - we might have a schizophrenic kid here or a kid is suicidal or, you know, a much more serious - - -

PROF KING: Like using a mallet to - - -

MR DE LUCA: Yes. So I put in an application to the principal because a particular school that I work at is having problems getting psychologists so I said, 'Well, I've got this Master's in counselling and I think I'm pretty good at what I do. Would you consider me having as a counsellor'. The considered it but they knocked it on the head.

PROF KING: So in a sense they - - -

MR DE LUCA: So I'm advocating that you need both in schools. You need counsellors to deal with less complex issues and the more day to day stuff.

PROF KING: Yes, can I push on that because in some ways our recommendation is saying - we sort of need people with your sort of background so the teaching background but also who are able to appropriately then, you know, have the considers. Is it just, yes, something temporary like, 'My favourite pet died' or is there something more going on and can start off in the classroom setting and can then link into the community so our recommendation says you don't actually have the psychologists in the school but you have the appropriate services out in the community but you have somebody who's got that teaching ability and has a relevant backing in - - -

MS ABRAMSON: Well, your own background to be honest, Terry.

MR DE LUCA: Your own background, yes.

MS ABRAMSON: But we were looking at your background up there.

PROF KING: I'm sorry. Just because you seem to be what we were after.

MR DE LUCA: Yes, yes. No, and it's - I would have stayed more in counselling if there was funding. I mean, I quite like what I'm doing and the moneys good.

PROF KING: Yes, but you said you feel you need to have both in schools. Do you really need the psychologist in the school if there are appropriate services in the community?

MR DE LUCA: Well, the school's perception is that we have a lot of kids who need testing, like, they don't know what's wrong them so they're going to find out.

PROF KING: So what does the psychologist do after they've done the testing and said, 'Yes, this person does need mental health treatment or something'?

MR DE LUCA: Then they probably send them off to a psychiatrist to get some drug or something - - -

PROF KING: Or they send them outside of the school anyway.

MR DE LUCA: Yes, yes.

PROF KING: To a service.

MR DE LUCA: I think the schools have problems giving psychologists, as least my school does, because of the workload that there's too much work and not enough time.

PROF KING: Yes. Or they only do assessments, they don't do treatment or something like that.

MR DE LUCA: Yes, that's right. I mean, you've got kids that might come every day for a chat.

PROF KING: Yes.

MR DE LUCA: And there's an hour or half an hour of time so it's a cost benefit analysis really.

PROF KING: (Indistinct words) questions?

MS ABRAMSON: Well, the only thing I was going to say is following on from what Stephen said. If you looked at a perfect model and you said, 'Well, we're going to provide this services in the community', I know we're not there by the way but if were, would you still be of that opinion that, yes, you do need to have psychologists in the school because they do this assessment process et cetera?

MR DE LUCA: I do but I looked at my own training and when I was putting forward my CV for why I should be considered I have 16 units of counselling and I've covered a wide range of areas like grief and loss and trauma and I think that - I don't want to waste that. That's useful and so - I don't know where that leads me but I'm just about ready to move out of education and into more private practice but one of my passions was actually to see if it was possible to get supervision for teaches because I think that is a really, really big need. But as soon as mention the word 'supervision' it's got a power dimension to it like you're watching the person.

MS ABRAMSON: What do you mean?

PROF KING: Yes, what do you mean by 'supervision'?

MR DE LUCA: Yes, that's right. Like, supervision is two pronged. As a counsellor you have issued that are very complex and you can be affected personally by the issues that your client brings up, you know, transference and counter-transference and you need to deal - you know, you need to debrief that but the other thing is you need a professional objectivity that say a client comes with this issue and, 'This is what I did' and they say - you know, you might say, 'Did that work and if it didn't work then we can have a discussion - - -

PROF KING: So it's like clinical supervision but of the teachers.

MR DE LUCA: It's professional development. Yes, so it's enhancing my practice so there is obviously, you know, the blind spots like we have lots of blind spots so, you know, even though I think I'm wonderful I'm not perfect.

PROF KING: Yes.

MS ABRAMSON: Can I just build on that because that's been really helpful. What do you think we could do about improving the knowledge of mental health amongst teachers?

MR DE LUCA: That is the million dollar question. That is probably the biggest question in schools at the moment. How do you deal with these kids who are really difficult? Now, I was just going to say that with all my experience and all my training I still have difficulty with kids. Now, I mean, I can cope and I don't take it personally if something goes wrong but - and I'm thinking, 'This poor teacher', young teachers especially and we lose about 30 per cent of teachers by the third year they've gone into teaching. Now, that's pretty damning I reckon. Anyway, we won't go there.

So young teachers really do find it difficult dealing with these emotionally complex kids who - and their parents, the parents are 'Not happy with what you've done with my child' and there's one teacher at the moment who's going through a lot of stress over that at the moment because they want to do the right thing and they want to do the right thing by the parents and the kids in school but they've also demanded a certain standard from the kid and whatever they'd done and it's caused them a lot of stress with all this negative feedback.

But anyway, I don't know the answer to that. I don't know how to do it. I mean, teachers are a very hard lot too, I hate to say it, but they sense the bullshit and so I've tried to work - I've done presentations to staff and, you know, you'll get some people that will buy what you're saying but you'll get a lot of people that won't.

PROF KING: (Indistinct words).

MR DE LUCA: Yes, and that's the way it is.

MS ABRAMSON: One of the things we focused is teacher trainings so that's part of the puzzle but it doesn't deal with the teachers already in the school.

MR DE LUCA: Yes, and it raised a big question, you know, they're not social workers, they're teachers. You know, they love their subject like I love history teaching and I really enjoy teaching history and that's what I wanted to do as a teacher and I do that, you know, but I may not get to teach history because there's no one teaching - doing history so I might have to teach English or geography which is not really what I like so there's already going to be blockages and dissatisfaction there.

PROF KING: Yes.

MS ABRAMSON: We're looking at you now, Harvey.

PROF WHITEFORD: No, I'm good, I'm good.

MR DE LUCA: But thanks very much for this.

PROF KING: No, thank you very much, Terry, it was good.

MR DE LUCA: I've really enjoyed doing this just because I wanted to have a say really.

PROF KING: Good for you.

MS ABRAMSON: Thank you.

PROF KING: Thank you.

MR DE LUCA: Thank you.

PROF KING: Perhaps if we have a 15/20 break. Perhaps if we come back at 3.35 from afternoon tea. Thanks.

SHORT ADJOURNMENT

PROF KING: I will reconvene. As I've done after each of the breaks let me just remind people, because people are coming out and that's why I do this so apologies if this is the fourth time today you've heard this - - -

MS ABRAMSON: I think you'll know it off by heart, Stephen, so it will be quite good.

PROF KING: Just to reiterate, no, I still have to read. As I've said we conduct these hearings in a fairly informal manner but there are clear structures in the legislation to how these hearings are legally backed and a full transcript is taken, that's what the microphones are for. Transcripts will be available on the Commission's website after the hearings as will submissions be but it is a public hearing and there are public transcripts of the proceeding.

We know some of you today are going to talk from personal experience so be aware of privacy protections and refrain from naming specific individuals and for any media here please make sure that you have identified yourself to the staff. Given the nature of the proceedings please be respectful in your approach. And the final one is the mobile phone, please make sure they're on silent. I think that's it.

You can sit there and if you can just state your name, if you're representing an organisation the organisation and any opening comments you'd like to make.

MS CHRISTIE: Thank you. Commissioners. My name is Julianne Christie. I'm actually no one of particular consequence, I am not - - -

MS ABRAMSON: You 're called Julianne, I'm quite on that one.

MS CHRISTIE: Thank you. I am not representing an organisation, I am simply sharing my own personal thoughts and opinions, so.

PROF KING: Which is great.

MS CHRISTIE: Thank you for hearing me today. The 1983 Richmond report provided the framework for the deinstitutionalisation of mental health provision in New South Wales. This decentralisation meant that the care of clients was transitioned to the community in a large way. The Richmond report recommended and closure and/or the downsizing of large psychiatric institutions and the transfer of that funding into community facilities and organisations for people with mental illness and other disability.

This was designed to support to development of innovative person led recovery care practices and models and this was also to capture the many social and economic benefits of community based care. However, the proposed funding transfers did not occur in the full spirit of Richmond recommendations and the closing of the large institutions was undertaken but the commensurate transfer of funding to the non-government community organisations to provide care for the clients that were now displaced from the institutions. We saw an under resourced under staffed community sector struggling to meet the needs of a now larger number of clients, consumers and carers.

The funding transfer failure of the cherry picked Richmond recommendations set out the pathway to where we find ourselves almost 40 years later with an increased population, a string of new and different stressors and a very different operating environment. The public hospital system, police and ambulance services, the judicial system and corrective services have all experienced flow-on effects and borne the brunt of this and subsequent inaction regarding the need for comprehensive, integrated mental health system delivery. It's not okay for these public servants to bear the abuse and it's not okay that people with mental illness are in public situations of great stress and confusion without the appropriate prevention and are measures in place.

The current state of affairs is a culmination of almost four decades of continued studies, reports, reviews, research, evaluations, submissions, senate committees, standing committees and other such enquiries but not a lot of change, improvement or progress. The plethora of previous reports actually carry similar recommendations. Families, clients, carers, workers and practitioners agree on key action points. There has been a united voice calling for change and outlining what needs to be done yet change has not been implemented. Why? Well, I think this is due to the fact that mental health is one of those complicated multifaceted issues whose continued attention and action exist beyond a political cycle.

Governments are reluctant to commit resources if they can't claim the credit for successes. Our governments have also done an amazing job of convincing the public that budget surpluses are more important than investing in people. Additionally, parts of the mental health system have been privatised and whilst we ask profit maximising enterprises to provide a public good then there will always be a system that is at odds with itself.

Your reform area four calls for assistance for people with mental illness to get into work and enable early treatment of work-related mental illness. Your notion of individual placement and support programs that reconnect people with mental illness into workplaces might need a little bit more attention though. You ask our business community to absorb people suffering from mental illness into the workforce at a time when they have endured the GFC and its repercussions for almost a decade. They are coming into unprecedented economic conditions with the lowest interest rates in history but with recessionary indications and no sight of government leadership through appropriate Keynesian spending and investment.

Continued international instability also gives an uncertain operating future. Our business community already absorbs the requirements of the school-based apprenticeship and traineeship programs, mandatory work placements for high school vet students, mandatory work placements for TAFE students, mandatory work placements for university courses. They also face the multitude of unsuitable applications that are forced through compliance with the Centrelink job application job search requirements and there's a number of other education based and government programs that our business community copes with.

In an increasingly complex operating environment you are facing a business community that is made up mostly of small to medium enterprises that is fatigued and saturated. It's going to be very difficult for them to absorb yet another high needs job program. This is especially so if mental health first aid training is not made available to employers, supervisors and staff. And while I'm talking about job placement can I suggest that selected government staff actually experience the system as secret shoppers if you will.

The quality of job streaming and job assistance provided varies greatly from business to business and suburb to suburb. Some are fantastic but there are countless experience where so much more could have been done to assist and I've personally witnessed it. Can I suggest that some creative problem solving is going to be needed to provide job hunters with mental illness some job hunting assistance. Resources might be better placed into social enterprises specifically established to meet the training and work experience needs of those with mental illness before being sent to participate in the wider labour market. Local councils might also be a source of training and work experience if they were properly resourced to supervise and implement projects outside of their adopted operating plants.

The people of this wonderful country need the studies to stop and implementation to begin. We deserve better government delivery, implementation, collaboration, communication and root cause treatment. We deserve better funding, better outcomes and clear roles and responsibilities. We deserve a visionary future where people receive the care they need quickly and simply. We need a better balance between community based mental health care and more funding for institutionalisation and dedicated hospital beds. We need ongoing workforce development and support. We need a robust system that can't be abused or railroaded but one that is evidence based accountable and responsive. We need an educated population that knows what resources are available to them should they need it or someone that they know needs it. We urgently need an end to the cost shifting between government levels. We need an end to studies that collect dust. We need an end to the lack of accountability and an end to the less than ideal allocation of resources.

We have a genuine opportunity to improve and secure our vision service visioned future for the mental health sector but unless we can secure urgent and enduring funding for action then we are destined to always suffer from the maladies of having world leading policy but poorly funded, poorly implemented action. We deserve a high quality comprehensive integrated system that does not suffer from a lack of political will but is more focused on budget surpluses than exploring Mars. That's my two cents worth.

PROF KING: Thank you very much, Ms Christie. I want to look at some of the things that you raised around the individual placement of support and social enterprise area and then I'll pass over.

MS CHRISTIE: Sure.

PROF KING: So your response there is similar to COSBOA's, Council of Small Businesses of Australia. Their initial response was to say, 'Oh, this is just going to be more red tape or more burden' and we understand that response by the way, we've tried to make sure that it isn't creating more red tape but at the same time our recommendations really do focus on that need to make sure the workplaces have the incentives to bring mental health to the same level of physical health in the workplace safety.

You mentioned those social enterprises failed one area that we looked at but we didn't really push very far and we've seen some excellent examples. There's one up in Toowoomba that everyone comments on and I went and visited that particular enterprise. How do you see social enterprises, if that's a doorway into training and then employment for people with mental ill health, how do you see that scaling up because whilst ones that are visited are great they do seem to depend on individuals who sort of say, 'Hey, I've got a great idea and I've got the time to be able to put this together and I'm just not sure that we have a robust program but depends on having the right people just happening to be there' so your comments on that?

MS CHRISTIE: I think that one of the barriers to people starting social enterprises or fulfilling their own dream but fulfilling a social mission at the same time is that that simple process of just starting a business is actually quite complicated and having some better assistance through the business enterprise centres and the business advisory services specialising in the establishment of social enterprises would certainly go a long way to reducing some of those barriers.

I think that in this particular case and using social enterprise concepts as a training ground not only if - well, I mean we could start this out with mental health as being the focus but it can also be assisting, you know, people that have been out of the workplace for a long time and all of those sorts of things but they can be set up and actually run and supervised by an oversight or government department or somebody that actually has that vision in mind, that this is a business that has been set up for the purpose of providing the work experience the training ground but it is staffed by people who understand the mental health nature of the employees.

So you would actually have to find people that are interested in setting up a business. They actually then wouldn't really be setting up their own business because it's funded or assisted set up from government so that you actually have got the oversight. You can train those people in mental health first aid or beyond in terms of what is expected and so these people are assisted in not having to bear and navigate the system of setting up a business by themselves but they've got that personality of wanting to run a business but they've also got the personality of wanting to help people. They're out there, it's just a matter of finding them and assisting them and it might be an expensive way of doing it but I actually believe it will work because it's certainly better than what we've got now, we don't have anything now, but I've also long wanted the idea of specially established social enterprises to assist other members of the community that have also got barriers to enter into the workforce.

This is a great way of specifically focusing on their needs, training the business operator to actually deal with whatever those needs might be and then when they hit the labour force they've actually got a verifiable work experience behind them because employers want people with work experience but they are quite reluctant to offer it.

PROF KING: Okay If we went down that sort of direction in our final report in terms of the recommendation, the first thing we will be asked is, 'Well, can you show us where this has been done at scale', as opposed to individual enterprises, 'at scale either here in Australia or overseas and can you provide us with the evidence that it works?' so I'm going to ask you the same thing. Are you aware of anywhere where this has been done at scale and then we've got the evidence there that this is a good way of going?

MS CHRISTIE: I don't but I'm happy to help you look.

PROF KING: That would be fantastic.

MS CHRISTIE: I just see this as a logical, empathetic solution to the problem and I think if it's been done it's certainly been documented. It would be amazing to have a national chain of restaurants or a national chain of cafes or a national chain of whatever it might happen to be, I can see a number of businesses set up in a number of different industries that will actually be that training ground and almost a revolving; people come in, they are trained, they do their traineeship, their apprenticeship, they have that work experience, they leave because they are now able to actually meet the needs of employers, they've got that confidence themselves, they've received those benefits of working because they are many and we keep going.

MS ABRAMSON: Ms Christie, you've given us a very eloquent presentation of what needs to be done. One of the things we're really interested in is how we get there and timeframes and priorities. In our draft report we tried to put - well, we didn't try we did. We put priorities over particular areas where we thought, 'Actually you really, really need to this now'. This one, it matters but it matters in a different timeframe so any thoughts you have on priorities we'd be very welcome.

MS CHRISTIE: I'm quite happy with the priorities that have been set. I think just that that forced item of - I think that needs a bit more fleshing out. I have actually worked closely with business communities firstly in just their daily operations and what they need, what they experience, what they worry about and I've also worked with the school based placement requirements of the VET program in schools and so I've been on the other side where there is endless frustration and worry about not meeting the study's mandatory work placement requirements and so I know the business is - they're tired and they just want to make a living for themselves and their families and there's just so much going on. So I'm quite happy with what the priorities are. I just think number four needs some more work.

MS ABRAMSON: Thank you.

PROF KING: Yes, thank you.

MS ABRAMSON: Thank you very much.

MS CHRISTIE: Thanks very much.

PROF WHITEFORD: Thanks very much.

PROF KING: Fox, if you could state your name, if you're representing an organisation and if you've got any initial comments you'd like to make.

FOX FROMHOLTZ: Yes, no problems. My name is Fox Fromholtz. I'm here today as an individual as a youth mental health advocate but probably primarily as a young person with lived experience of mental ill health and of recovery. I'm here to address probably two particular key points. Both of them pertain specifically to the comments in the draft report regarding Headspace and recommendations around Headspace.

As a young person I'm between that 12 and 25 bracket so I sort of feel qualified to address some of it. So the first point I'd like to talk about is I believe it's draft recommendation 5.3 about linking Headspace funding to the proportion of referrals made to low intensity services. So low intensity services obviously have a lot of value as evidenced behind them but I would caution behind linking funding to that and in particular pushing that towards young people. With that I would recommend if you're going to kind of talk about that then actually potentially consulting young people about recommending those. Potentially young people were consulted in this report, I'm not sure.

I think there's a perception in the report, at least that I got, that young people - young people are definitely technology savvy but that doesn't mean that they necessarily want access to counselling online. I know from my experience that it hasn't been very helpful for me. I know for a lot of my cohort it's not necessarily - it works for some people, it doesn't work for everybody. There is kind of a difficulty with young people and getting into lower intensity services so things like NewAccess coaching is just not appealing to youth. Now, that might be that they just don't know what it is and they have misconceptions but it's something that probably consultation with young people would be helpful with as to see why before pushing that young people should be recommended to these services.

My concern is that if I had been told at the time of seeking help, 'Look, you know, you can', - and I presented, you know, full disclosure as someone who's within the mild to moderate rate, there was no severe kind of thing so I didn't need any really high level of support but if I had been told at the time of seeking help, 'We'll recommend that you go to this group therapy. We'll get some short coaching or go line' there's a high likelihood that I would have disengaged with support services and this kind of not backed up necessarily but I did look at some of the evaluations that were cited in the study.

One of the key points that was made in the study I think it was (indistinct words) was that for most young people the individual relationship with their Headspace practitioner formed the core of their experience with Headspace and was fundamental to improved outcomes and that's talking about a one on one relationship with a practitioner. Lower intensity options, I'm not saying that young people should use them but I would really caution linking funding to that and I would really caution using a blanket approach to say, 'You're within this range and you should do this'. I do recognise that the report says that those decisions should be made in consultation with a young person but that's quite a difficult decision to make if you are pressuring people into those services.

So in terms of that I would probably - my recommendation would be to really consult with young people on any recommendations that you're making particularly around Headspace because Headspace is a primary provider of youth mental health services. It's not the only provider but it is, you know, one of the major ones if you are making recommendations towards what Headspace should or shouldn't do you really need to consult youth about how that's going to impact them and their engagement with the service.

The second point that I'd like to make is just in regards to some of the reporting on Headspace outcomes. So the report states that Headspace has been evaluated to be only modestly effectively, that was two studies I believe that were cited both from 2015, that data is potentially outdated now but that's not really the key point. What I'd like to address is that the data sort of heavily relies in the K10 analysis and that there was only an 8 per cent reduction in distress or something like that in one of the graphs for young people in the evaluations that were cited. I'd like you to potentially consider that K10 isn't the best or overarching way of measuring outcomes for young people. There is early evidence to suggest that young people view recovery in a different way to perhaps other ages or other members of the public and I know from myself that that has been very true. I know that when I receive support for my mental health, my K10 and DASS scores for the first couple of years that I received support probably didn't change very much but my life outcomes changed so I had less missed days of work or I was able to get a job first of all, I had less missed days of study, I was able to engage with my studies better and my grades improved but my psychological distress remained on paper relatively the same.

And in I think it was (indistinct words) I couldn't get access to the other studies cited, they also note that one of the more important findings in their evaluation was that the improvement that can be seen in other valuable outcomes other than the K10 are most notably a reduction in suicidal ideation and self-harm for those receiving Headspace treatments even among those for whom the K10 measures of psychological distress showed little change. Economic and social benefits from improved mental health functioning are delivered through a number of positive outcomes and the extent to which these can be attributed to Headspace treatment (indistinct words) to the Headspace investment so those economic benefits were a significant reduction in the number of days lost due to illness, number of days cut down and reductions in suicide ideation and self-harm so again it's been my experience in receiving support and recovery and I know that it's the experience of a lot of my cohort. So I guess with those two key points my underlying message would be to talk to young people about what recovery of mental ill health means to them and how it might be different from the general population before making recommendations in regards to Headspace. And I actually would be curious to know if any young people were consulted in this report?- - -

MS ABRAMSON: They were, Fox. I can respond directly if that's all right, Stephen.

PROF KING: Yes, please.

MS ABRAMSON: It's like all cohorts of people though. You all have slightly different views so we certainly did, we had mental health commissions assisted us with convening four of their young group and it's true to say that we got mixed responses so we had some people - I think the overwhelming message we got was there's all this information out there on the internet and we don't know what the reliable information is and people said to us, 'I got to my treatment because somebody recommended someone to me' so we can always consult more and I'm really grateful that you've made the time to come and talk to us directly but I think it's true to say that we got a mixed response.

PROF KING: Yes. Although one of the things that - I think your comments on the evaluation of Headspace are really interesting because if I can rephrase your words, you were saying if Headspace is going to be evaluated it's got to be done in co-design or the evaluation has to be co-designed with the young people and I think that's really good input quite frankly.

MS ABRAMSON: Yes.

PROF KING: I think that's really good advice which we need to take on board because - yes, evaluations are done - if they're all done through the same frame we know they're not going to be necessarily effectively and measuring the right things so I think that's something very good but a lot of intensity services, I guess in some ways you're saying part of what is a broader problem that we place in our report - well, the low intensity services that are moderated online which is the one that we were looking and PORTS is the WA model which has (indistinct words) and we're seeing the evidence that they're very useful for some consumers but we're facing a clinical system, of which headspace is a part, where there are incentives, there are practices and there are cultures which say, 'Well, you know, you've come in through this door, face to face counselling is the way to go' and there's government money behind face to face counselling. So we're trying to think how do we change that culture because if we're going to use our existing workforce better and build the clinical gaps in the system then we have to think about, 'Well, how do we make sure that the people who are best treated through the sort of moderated online but low intensity services are given that as a real option?' and often you depend on clinicians that present the options so I guess that's where that particular draft recommendation that you mentioned for headspace came from but it's part of a broader story and I'd be really interested in getting your views on how you know, how should we be thinking about that because as you presented (indistinct words) and it's not something we're necessarily particularly comfortable with either but we're not sure how to do it otherwise.

FOX FROMHOLTZ: Yes, and it is - I recognise it as tricky and I'm not saying that low intensity services have no value, I've seen the evidence myself particularly in regards to things like NewAccess is really strong and it's behind that and going online is a really valuable thing particularly for people who might not otherwise be able to get to a centre or might live in rural or regional areas. I think taking a blanket approach and linking - particularly linking funding I think that's quite uncomfortable the idea that there's this sort of pressure to be pushing people into something that they might not necessarily be interested in and again you obviously - you know, people aren't going to be forced into something but whenever you do have that pressure there is that conflict.

I guess to me I think part of the thing- and I recognise that the lower intensity options were throughout the report as well, I did read up a fair bit of that because I wasn't quite sure on what was meant by low intensity initially. I think particularly with young people, groups are not popular and they potentially be beneficial but I think a lot of young people might have stress or anxiety or just might not think it sounds very cool to be honest and whether that's, you know, thinking about ways to rethink low intensity options in terms of either how they're marketed or how they're delivered to young people and again consulting young people on that, you know, you could see an increase in young people wanting to take up those options.

I think a lot of people do use online support but they might use it as an interim support to get face-to-face contact. I just know personally that a lot of people I speak to do want that face-to-face contact even if, you know, like potentially low intensity might have evidence that it could be helpful for them, it's also to do with what young people want and what they're going to engage with.

MS ABRAMSON: We're very open minded about this, Fox, so if there are ways that we can get young people to treatment and if you had the time to put in a submission, even a short submission, we're very interested in that and I suppose some of the thinking behind the low intensity was first of the evidence was there but the other thing was we were struggling with trying to get the right services to the right people at the right time and we observed that, you know, with the better access that people were only using a small amount of the session so part of our thinking was, 'Well, how can we get that treatment to people who might need more of that cognitive behaviour therapy?' so that was kind of the thinking that sat behind some of our views on low intensity; (1) it worked and (2) how could we reallocate resources?

FOX FROMHOLTZ: Yes, and it's definitely something to look into. Yes, looking at some of those platforms aren't particularly youth friendly. I know with NewAccess a lot of its done over the phone, a lot of young people are not comfortable over the phone - a large proportion of young people are not comfortable over the phone. Even things like eheadspace where you can talk to somebody over the phone, most people will chat online which can be helpful but again it lacks that - a lot of connection and, you know, kind of as one of those evaluation states that connection with a practitioner is something that's been fundamental to headspace success according to that evaluation.

So whether it's looking at how those lower intensity options can be looked at in terms of how they can be more youth friendly - I mean, the reason things like headspace and ReachOut et cetera were set up for young people was because young people weren't engaging with mental health services because they weren't particularly youth friendly and it's also difficult for young people; to have their voice heard in that arena and even, I mean, you know, even in like a forum like this it's quite difficult for a lot of young people to come to a form like this and present at a hearing and things like that so that's where that consultation comes key. But I also would stress again kind of looking beyond just things like K10 measures and looking at other outcomes for young people or for everyone in general, particularly young people.

PROF KING: Thank you.

MS ABRAMSON: No, that was terrific, thank you.

FOX FROMHOLTZ: Thank you.

PROF KING: Jane, thank you.

MS JERVIS: Hello. So I'm Jane and I'm just representing myself not anyone else. I'd like to talk about reform area four and 19, mentally healthy workplaces, and D2, workplace bullying. So imagine this: your boss waves a medical certificate back to you. 'It's not detailed enough for me. You need to go and get another one'. She gets a HR rep who says, 'Get the extra certificate and then he'll determine if he wants to get an independent assessment'. She comes to your desk, 'Get me copies of your certificates or I'll notify payroll and get them to dock your pay'. She doesn't sign the certificates, waits until you've left for the day and tells payroll. She picks at random one of your next leave forms and tells you, 'Move this time to this' which isn't correct. Meanwhile your work, it remains ignored, stonewalled and stockpiled by both her and her boss. She gives you tasks unrelated to your job and lower than your level just before you need to leave the on doctor prescribed half days or it's what she's had for two weeks but allocates right as it's due.

She emails you and when you reply she responds immediately with, 'Communicating with email is ineffective'. Her other emails say, 'Communication needs addressing. You're creating inefficiencies. You don't have any initiative and you're not demonstrating a willingness to meet the capabilities of your level, a willingness'. Another HR rep responding to the formal report you made emails, 'I haven't found anything to indicate bullying. Here's a link to the code of conduct and guidelines and I'll be speaking to your branch head shortly' and those examples are only slices of what happened in that particular experience and it's not your first experience with workplace bullying either not in that organisation.

You finally quit with PTSD. The bully gets higher duties, the HR rep who responded to the report got promoted an award. So this inquiry's about mental health and this is relevant and the effects and tolls of being bullied at work are enormous. You have freeze-fight-flight, uncertainty of what to do, always having to think about how to respond to the bullying tactics being used which distract you from work related to your job which you're still trying to do and you're still trying to progress. It shrivels you inward and you're in a spiral thinking over and over what's happening and what are you going to do, what are your options and what's coming next because there is something coming next, you're just not sure what that is and you're tired and drained and exhausted and you don't want to drag yourself to work but this is your job and I haven't said any about what you are of value to your organisation either.

Tactics used by bullies try to force you into a dance of sorts with them where they'll want a reaction out of you and you will question and you will explain and you will stand up for yourself but they're responding in anger and dominance and using more bullying tactics. You're their target they've locked onto, they're firing and they're going to keep doing that to prevent you doing your work, to put you down, to belittle you and to give you negativity and you're shocked and baffled and annoyed at the injustice of it all.

And then you have thoughts about, 'How can this be any good for the organisation?' and 'This can't happen to anyone else, what can you do, do what you can' but what if I didn't have to deal with this. What did it look like if I had a clear run if this wasn't part of my story, if I didn't have bullying to deal with. Did I choose the right path when my skills and attributes and personality wasted in here? It's compounded if you decide to make a report and then compounded again if you do and then experience how it's handled. Abuse from a bully, because that's what it is, it's abuse, it affects areas of your mind and you're psychologists here so you'll know what that matters but shatters your ability to think straight, clearly and normally. You feel increasingly miserable, you sound different, you look different, you're aware of it and other people are too including the bull though who knows that it's working and that it's affecting you.

Workplace bullying is sick and what was a healthy person from workplace bullying is now sick and you've heard examples from other presenters today about people with mental health needing understanding to get into work and I'm describing examples of if you've been bulled to the extent that you can't cope with that anymore under those circumstances and your last resort is to quit and then you're out of work and you're sick. A recent report seemed to indicate thousands, more than 14,000, federal public servant respondents in a survey with a high response rate have perceived harassment or bullying in the 12 months prior.

A series of media articles about [workplace name] describes people being mistreated whose job it is to take care of people. 'Do no harm' is an industry motto. Only after the media exposure I think was there an independent review into culture there and what's the whole point of public services? To serve the public. The bullied ones who can't do their job can't serve the public. The ones focused on themselves doing the bullying that probably has a lot to do with power, control and status; how much are they thinking about being of service to the public? Is it any or is it none? Personnel wise, if organisations let higher duties and promotions go to bullies, those with attitude focused on self who are a bit slick and clever with how they're portrayed so that it helps their position and then individuals make calls on behalf of an organisation that are contrary to the law or guidelines or shuffle the problems around, then that organisation's human capital isn't healthy either.

So in terms of the work itself what can't a bully whose been bullied do while they're being bullied and that's their job, you can't function normally under bullying tactics and bullies are blockades. You're giving your value to making your contribution and to helping others and not only is it appalling enough to have to deal with the bully, the abuser, the perpetrator but then to experience what happens if you do make an informal or formal report. In one of the workplaces someone in the executive eventually seemed at a loss and at wits end to the because they can't stop the bullying either so as an aside to you they mention there is the Fair Work Commission. How bad must it have been for that to happen and it's almost as if the executive seems to be letting you know it would be okay if you were to turn the mirror out in order to look back in.

Also imagine though if you've had other situations where a HR rep says over the phone, 'Oh maybe we shouldn't have employed you in the first place. Can you please send me a copy of your resume?' You get a better response when her boss gets involves who says to you towards the end, 'Don't quit before you do'. A safe work employee calls asking, 'Has she ever shouted at you because it's not bullying if you've just been shouted at the once?'. His manager, who you elevate the matter to you, is having trouble getting information out of the workplace so he asks you if you can cough up any names of anyone he can talk to but you don't because you don't want someone who may not wished to be named to be named in an external environment. He emails a copy of his report finding an offence under the Workplace Health and Safety legislation is unable to be proven beyond reasonable doubt, a bit trial like.

Writing on a CEO's behalf and a herd of people equivalent that person says, 'No further correspondence will be entered into, to shut it down'. You can't say certain people don't try everything. Someone who's had the guts to report bullying shouldn't be put under more pressure by having to explain to someone in an oversight role or a review role that they're now not saying something which seems at all to make sense or be appropriate or in line with law either or having what you've raised be minimised, shrugged off or shut down. Deal swiftly and accountably with staff who continued to be out of line after they've been called out. What are individuals in HR up to? What calls are they making and who's aware of them about what they're saying on the organisation's behalf? And people who are in one of those HR line areas, they're not above scrutiny either.

Bullied workers do consider workers comp lawyers no win no pay and going to journalists to tell their stories because of the severity of the impacts of PTSD on their mental health. So my main concern I suppose in looking at the sections that relate to psychological safety at work is around you can still have law or you can still have guidelines but then what happens? How were they followed and what do individuals make a call on? And is it an accurate and a correct call that people elsewhere would be willing to agree with, would the head of the department be willing to agree with that when it is potentially something that could go through workers comp lawyers/journalists.

MS ABRAMSON: Ms Jervis, thank you for putting that on the record. These are difficult things. What would you see in terms of solutions? Like, what would the type of things - because we've thought about this a lot, we've got a section in the report which deals with bullying but what type of reforms would you recommend?

MS JERVIS: I think the main bit is you can have as many pieces of paperwork and everybody knows about that, you have to sign paperwork when you start a job, when you open up your computer screen you've often got to click a button to say 'I agree with all of the code of conduct and how I'm going to treat people'. It's everywhere. All of it is known but when you actually do have instances where someone has been mistreated and bullied at work then if they need to follow what they're supposed to and then they do submit, 'I've been bullied', it's the receptiveness to the people to hear what you've said to look at the evidence and then what do they do with it and then how accountable is that and how transparent is that so I think the gap tends to be often what people in organisations can do and I would say organisations, HR line areas, do play a big role and I have had some HR representatives who have been knowing what has been happening but the examples that I've just given you now about some of the responses of, 'Should we have employed you', 'Send me your resume' or 'I'm backing up the bully, go and get another doctor's certificate and then I'll make a call about an independent review of it or know there's been no bullying' when there clearly has been - - -

MS ABRAMSON: I'll come back to the point. Like, this is a report where we can make recommendations. I know you're talking about workplace culture and that's a really big issue but what practically would make a difference? What could we actually - - -

PROF KING: What could we recommend.

MS ABRAMSON: Yes.

MS JERVIS: So something in there in reform area four where it says there'll be guidelines or making mental health in the workplace just as important as physical injuries, if there's something in there around there needs to be integrity and accountability of people in the system in what they say and do so I think that that is something different to just saying organisations must have a guideline.

MS ABRAMSON: You see, the other thing we've thought about which might not be particular to what you're talking about is workers' compensation so we've really been thinking about a system. What can you do in terms of getting people back to work and making an incentive for an employer to behave in a certain way?', so we've been thinking about that.

We get that it's a broad pictures but we've been thinking about, 'Well, how can you incentivise the system because we observe that people who are away from the workplace with a mental health issue, they're away longer, their return to work is less likely, so we have thought about some of the compensation recognisance. I don't know if you wanted to add - - -

PROF KING: Well, I guess we're still trying to think about where can you get leverage from outside - - -

MS ABRAMSON: To change people's behaviour.

PROF KING: To change people's behaviour or change organisation's' behaviour and one way is using the workers' compensation so saying, 'You should get premium discounts as an organisation if you are putting in place validated mechanisms to stop things like bullying' in which case you literally get a financial award and of course the opposite occurs if there's any bullying and workers' compensation claims due to that so, I mean, I guess it's sort of a crude mechanism but I must confess we didn't know what else to do, what other levers (indistinct words) to do?

MS ABRAMSON: Well, there's one other issue, and I'm indebted to my staff here, transparency around reporting bullying incidents.

PROF KING: Yes.

MS CORMICK: It doesn't go anywhere.

MS ABRAMSON: Sorry?

MS CORMICK: It doesn't go anywhere when people report bullying.

MS ABRAMSON: Yes, we can't - - -

PROF KING: Sorry, yes. But we will actually open up for other people so if you wanted to make that on the record - - -

MS CORMICK: I didn't mean to say it.

PROF KING: No, no, no, please.

MS ABRAMSON: No, it's a - - -

PROF KING: It's perfectly fine, it's just that we can't formally record it that's all.

MS CORMICK: That's fine.

PROF KING: Sorry, yes.

MS ABRAMSON: But the two are linked.

PROF KING: Yes.

MS ABRAMSON: What Stephen's talking about in terms of premiums and reportable incidents of bullying so the two are not unrelated because if you're looking at somebody's premium than an insurer - I know we're getting into technical detail but we're thinking about what they're talking about.

PROF KING: Yes, (indistinct words).

MS ABRAMSON: Yes, so the insurer then becomes aware, 'Well, you know, if there's bullying of one person there's likely to be bullying of other people as well' and it's about patterns of behaviour over time so that's one of the things about transparency of reporting. I mean, I take your point but if it's got a point that somebody actually looks at that data - - -

MS JERVIS: That would raise the question of how does someone who's raised bullying and then there is evidence but then they're told that bullying doesn't exist and bullying hasn't happened? Then what happens there? How is a report handled or how is a report covered up? If there's coverup/denial, then how does that individual feel in terms of being able to even - you know, what is the path for workers' comp? And if they feel like they've been told, 'That did not happen to you. That is not bullying. That is acceptable. We're going to give that person higher duties and oversight of even more people' and the person who told you that bullying did not happen, from HR, is promoted also and given an award?

MS ABRAMSON: Well, what would an outcome look like? As I said we're talking about (indistinct words) because we're thinking about workplace culture. How can we incentivise it? So if you had your choice what would you say would make a difference?

MS JERVIS: I think it is accountability and transparency and integrity of how matters are handled because - - -

MS ABRAMSON: So is that about the internal - I'm a lawyer by training so I'm quite interested in this - so is it about the transparency of the internal processes for resolution of disputes that there would be some oversight elsewhere in a large organisation?

MS JERVIS: In another part of the organisation?

MS ABRAMSON: Yes.

PROF KING: Well, to avoid - you know, let's say - I'll pick on the public servants - but let's say there is a culture in a particular department or part of a department where even though formally there's mean to be transference, if there isn't where bullying claims aren't taken appropriately, should there be in a sense somewhere else that the person can say, 'Look, what's happening here in this department isn't right. It's not transparent, it's not an open process'?

MS JERVIS: I think the executive, if you've raised it with them then they know what's going on but, you know, I think HR, if that is where normally people go to, then perhaps there's scope there for HR representatives where there have been cases of bullying need to be perhaps trained and understand what bullying is, what is their response supposed to be - - -

MS ABRAMSON: You see, a lot of organisations, and I'm not talking about a particular organisation, but these are risk events that need to be reported so they're actually reported to a particular committee that there's X number of incidents this month so, I mean, I get your point about if the people who are dealing with it don't regard it as a bullying incident but overtime you can a number of incidents which are reported to risk committees usually so that's why I was just asking you about mechanisms around that because you said, very helpfully, 'Well, it's about transparency and accountability' but in the corporate world we tend the build that by a reporting mechanism through to particular committees who have that responsibility. It sounds like a very bureaucratic thing but it's about risk management to be honest. So it's about who has have line of sight of what you're talking about at a senior level.

MS JERVIS: So, yes, HR would as would executives and - - -

MS ABRAMSON: But HR reports somewhere which is my point.

PROF KING: Yes.

MS ABRAMSON: So it's not just a matter of what's in their bailiwick but they have to report incidents especially of somebody's off on compensation payments then it has to be reported somewhere.

PROF KING: So would it be to the order of a risk committee (indistinct words)?

MS ABRAMSON: Yes, that's right. We're just thinking aloud about your accountability point and transparency.

MS JERVIS: Yes, so I don't think that there wouldn't be reports but it does come down to the handling of it and if there are instances where it hasn't been handled well then I suppose you two don't know - does that then become, 'This is the standard we accept' and that then becomes, 'This is how we handle cases' and 'Once before I've followed a process to find bullying did not exist so next time I get a case bullying did not exist?

PROF KING: Yes, so the individual case that you've obviously gone through, it's almost like it was your word against somebody else's word. You said, 'This is what happened to me'. They said 'Nothing happened to you. That's an over simplification' and at a macro level if that's the culture there should be more people like you who are getting that same outcome that it didn't exist and more people saying, 'Well, it did'. If that could be collected and that place is identified as a work environment where there's lots of psychological injuries occurring, could it be handled the same the way that it was a workplace where there was a lot of physical injuries occurring and some action had to be taken to make that a safe workplace? So it's almost impossible for us to deal with an individual case in an individual workplace but if the culture's there that lets continue what you went through, then somehow we have to be able to shine a light on that - - -

PROF WHITEFORD: There should be pattern of (indistinct words) macro level or institution level (indistinct words).

PROF KING: And take action.

MS ABRAMSON: That's right.

MS JERVIS: Otherwise it goes on and on.

PROF KING: Yes. I mean, that does not in any way diminish what you've said.

PROF KING: No.

MS JERVIS: You've been very courageous to come and talk to us but it's about the usual observation is, as Harvey said, there are patterns of behaviour and they're observed over time. It's not just one incident, it's a number of incidents that build up that we need to think a bit about.

PROF KING: Yes.

MS JERVIS: Or in one of the other examples there was someone who was known to have been bullying and it wasn't fixed until that person retired just with them retiring, so.

PROF KING: Yes, so - - -

PROF WHITEFORD: Which is unsatisfactory.

MS JERVIS: Yes.

PROF KING: And so the pattern was hidden.

MS JERVIS: Yes.

PROF WHITEFORD: So that person's bullying continued and for some reason that environment protected that bullying person or hid the outcomes on the people who were bullied and I guess that's the most toxic place you can get and so trying to pull that open and shine some light in there and identify that so it's not hidden and ongoing, is what we're trying to think about, a mechanism to do that as would occur if you were breaking a bone every time, then somehow that would be collected, there's multiple broken bones from a certain machine or whatever that doesn't work and that's transparent, - - -

PROF KING: That's then reported and - - -

PROF WHITEFORD: Yes.

PROF KING: And so even if the workplace says, 'No, the injury wasn't due to the workplace', well, it's still an incident that has to be reported and logged and as that information gets gathered up it becomes a body of evidence or, 'Yes, it is the workplace that's at fault here' even though the workplace may be claiming otherwise.

MS JERVIS: And with procedural fairness there is not a lot that can really be told to the person that reports so even if sanctions were applied I won't know that. If sanctions were applied, did they work?

PROF KING: Yes.

MS JERVIS: Did they have enough sanctions available?

PROF KING: And that leaves the individual in a very unsatisfactory position.

MS JERVIS: Yes, if the end result is that you quit as a last resort because it's too bad and you've tried everything that you can but you still mourn not having been able to stay in there and what if you had had a clear run?

PROF KING: Yes. Thank you very much for coming in (indistinct words). We don't have any solutions at the moment but we'll work on it.

MS JERVIS: Thank you.

PROF KING: Thank you. I'm not sure how many of you were here earlier on but normally we allow a bit of time at the end for people who, if they'd like to, haven't registered officially to make a submission but would like to do so and I'll look to you first because you did want to make a comment. Would you like to formally make a comment on the record?

MS CORMICK: Well, yes, I don't care if I'm in regional - - -

PROF KING: Yes, so please come up. So you're happy to state your name and - - -

MS CORMICK: Oh dear, okay. I haven't prepared anything.

PROF KING: No, no, no.

MS ABRAMSON: You don't have to, there's no obligation.

MS CORMICK: My name is Mary, Mary Cormick. I'm a public servant. You know, I know what Jane's been through but it's not only Jane, I know several people that have been bullied in the public service and they're bullied by managers who appear to be very professional and nobody seems to be aware that they're a bully, certainly not their superiors. I think the bully down but they act differently up.

PROF KING: Right, yes.

MS CORMICK: I don't know, it just seems to a bit prevalent and the people that I know that have been bullied they suffer post-traumatic stress disorder. It's really serious, you know, and it's ignored.

PROF KING: Yes.

MS ABRAMSON: Well, if you had - what would you do differently? What would make a difference in terms of recommendations?

MS CORMICK: I'd have psychologists on the panel for everyone that's going to join the public service and, you know, if they're going to get promised I don't know - look, it's a really hard problem. Psychopaths can pass psychology tests I know but I don't know, I've thought about it and I don't know - okay, like, what Jane said, HR areas don't do anything about it. Something's got to change in HR areas of departments - I don't know what, it's just a very hard problem.

But, you know, the workers' comp that's going out for workplace bullying is really going through the roof. People are, you know, having to pay money for this and that's what's going to make a difference, when money goes out the door money talks and that's when things will start changing. People don't know what else to do so they're going to the no win no pays, they don't have a job, they've had to leave their job, because of the bullying they're out of work.

MS ABRAMSON: Well, we have thought a bit about mental health literacy, for want of a better word, so would you see a role in HR for people to have further training in understanding mental health issues?

MS CORMICK: Absolutely but, you know, people can move around in public service departments, they don't have training in anything, they've just got to do an expression of interest internally and go to a different area in the department. You know, people aren't trained for the areas they're in most of the time and if somebody is in there that's trained they move on to another area and someone else comes in and fills their place so there needs to be a protocol that's really adhered to somehow, I don't know.

PROF WHITEFORD: Can I ask you a question. So the example you gave where WorkCover claims are going through the roof - - -

MS CORMICK: They are.

PROF WHITEFORD: Say if I was the chief executive of a company or a department and I was having my - the amount of premium I had to pay going up and up and up and up because I'm having repeat injury to my workers and I'm accountable for that payment. I've got to find the money to pay those increased premiums, we would have thought perhaps that that would shine a light for the chief executive equivalent that I've got a problem as it would in a workplace which was toxic because of air pollution or toxic because the machine is injuring my workers on a production line or something - - -

MS CORMICK: Yes, so you don't have safety railings somewhere or something.

PROF WHITEFORD: Exactly, so if we could try and say that a psychological injury is as bad, and some often worse - in fact from what the figures are of the physical injury, then we need to get that out into the open so that we respond to it the same way we would as a 'physically' unsafe workplace.

MS CORMICK: Yes. I mean, it's obvious a physical injury there's blood, there's broken bones, but a psychological injury through workplace bullying leaves people with PTSD and people can't see that but it's there.

PROF WHITEFORD: But the WorkCover claim investigation process or the Comcare claim is to find out whether there's an injury. Injury is a diagnosis so a diagnosis of PTSD is an injury so equivalent if it occurs in the workplace so that legislatively should be treated the same as, 'This person's broken a bone in the workplace'.

MS CORMICK: Absolutely.

PROF WHITEFORD: 'They have the injury'. And workplaces that are unsafe from that point of view should be responded to in the same way as I would see a place where everybody's getting asbestosis or something.

MS CORMICK: Yes, so why isn't it like that?

PROF WHITEFORD: Well, I guess that's our question, that's where we're going.

MS ABRAMSON: That's right but we have some recommendations around this where we've - even though the mental health of the workplace is actually encompassed in the work health and safety duties what we've said it needs to be elevated so that you can see that it's on equal footing with physical injury.

MS CORMICK: Yes.

MS ABRAMSON: So we've thought about - it sounds a bit abstract but we've thought about the legislative levers and as I said we've talked about compensation because we're thinking about how can we actually change behaviour and those are the things we've been thinking about.

MS CORMICK: Which is the hardest thing in the world but money talks and when there's money going out the door that changes behaviour.

PROF WHITEFORD: Yes.

PROF KING: That's why we're thinking about workers compensation (indistinct words) - - -

MS CORMICK: Yes, yes.

PROF KING: As being the lever there.

MS CORMICK: It would be great if you make some sort of recommendation that really makes a change in this area because it's really needed.

PROF KING: Okay.

MS CORMICK: I have a friend who five years ago was bullied and whenever I talk about it or she does she bursts into tears. She's very competent and she's manager level, you know, it's just terrible to see it.

MS ABRAMSON: Well, thank you.

PROF WHITEFORD: Thanks very much for taking the time.

MS CORMICK: Thank you, sorry.

MS ABRAMSON: For your impromptu appearance.

MS CORMICK: I didn't mean to butt in.

PROF KING: No, no, that was very good, thank you.

MS CORMICK: Okay, thank you.

PROF KING: Would anyone else like to make a statement, make comments?

UNKNOWN SPEAKER: I guess I'll just add to my - - -

PROF KING: You'll have to formally come up here to add - sorry, it's just that it has to be on the transcript.

PROF WHITEFORD: Someone's put up their hand behind you.

PROF KING: Sorry, yes. Yes, please.

UNKNOWN SPEAKER: Yes, David would like to.

PROF KING: Again if you could just state your name and if you're from a particular organisation representing them state that otherwise - yes.

MR LOVEGROVE: Hello. Look, thanks very much for the unexpected opportunity to be able to say a few words. I came here mainly to be an observer but it's great to have a chance to, even in a more conversational dialogue say, so I have an unprepared sort of few words.

PROF KING: But first your name just for the transcript.

MR LOVEGROVE: Yes, David Lovegrove is my name. I'm a health and wellbeing advocate of the last 16 or more years and a mental health advocate by lived experience for the same period and I've also previously worked in the public service - Australian public service - as well as training and practicing as a stretch therapist or stretch teacher over a number of years as well just to get that physical balance to mental health work. But, you know, I don't represent any organisation here today. I'm here as an individual and just observing the good work that the Commission's trying to do in terms of furthering the cause of reform in the national and local mental health systems as they are.

So, look, I was just wanting to really pick up something that was touched on a couple of times and I acknowledge some of my other colleagues who are speaking out of lived experience as well but just on the question of how do we value lived experience best in the systems and where would we focus our attentions?' and I think one of the big problems I've had over the years is there seems to be a cultural and systemic resistance to actually investing in structures that actually foster the lived experience voices perhaps beyond - perhaps calling on people to give their personal stories so I've been working mainly in systemic advocacy over those 16 years so lifting the lived experience stories into those voices who can't otherwise sit on committees or decision making bodies to actually get the lessons of those stories into those arenas and I think there's been - it just strikes me, there's lots of calls for the need for having the consumer focus system and to have, you know, people with lived experience involved in policy and in a whole lot of different areas but no one really wants to invest in structures that actually foster that and I think that's a huge issue across the whole country as well as at the local and grass roots levels.

So, I mean, we're lucky (indistinct words) in a sense we've got a consumer network, ACT Mental Health Consumer Network, we've got - now we've got a lived experienced consumer mental health research body at the ANU which is great so we've got some building blocks. We're starting a recovery college that's co-run by people with lived experience so slowly we've got to start building these building blocks but I think in terms of feeding into the rest of the system and within and beyond the mental health sector, there's a lack of really wanting to get that collective voice established and in structural or systemic ways and I think that's a real problem, whether it's even developing peer workers, peer work services, often we're just tacked on the end of - at the bottom end as it were of already, you know, very hierarchical class sort of driven system of authority and priority in terms of peer worker service and it's a really dilemma for people with lived experience who do bring a lot of other talents than their lived experience of mental illness on mental issues and that could really bring a lot of value to a whole ranges, like previous colleagues mentioned, a valuation but I think that's not the only one.

Perhaps that's a false question to ask, 'Which part of the system would we employ lived experience if we had that choice or if we only could pick one?'. Well, I think perhaps that's a false way of putting it because I think people come to the system with a whole lot of abilities and skills but if they're working through lived experience that takes a whole new dimension and a lens for which to approach the way that people can be helped and to recover for themselves as well as for those that the systems are there purportedly to be wanting to, you know, help recovery and to be productive and, you know - well, members of society so - yes.

PROF KING: Can I ask a question on that. So in some ways, you know, there's the formal peer workers, people lived with experience being formally involved, there are many people with lived experience of mental ill health who will be reluctant for a variety reasons but including stigma to identify - to take on the role of saying, 'Well, yes I've been there. I can offer support' because it affects the perception of themselves. Can you see any way that we can help or reduce these stigmas as being partly a barrier to broader engagement of people with lived experience in the community and, if so, do you have any thoughts about how we might address that or (indistinct words)?

MR LOVEGROVE: Yes, look, I think it does definitely, stigma, and discrimination are huge barriers and often where you wouldn't expect it most within the mental health sector itself and within services that are there to in some ways help people but that's all the more reason why I think we need identified structures and institutions that help that are there to bring out those with identified lived experience who are wanting to not be totally identified as that's their whole identity in life but see their work through the very process of using their lived experience to help make it better for other people who experience similar things and to bring lessons to the wider community and society about how they can do things better in terms of making life and supports for people more effective, more win/win for everyone in the community and society so I think that just reinforces the fact we need this set of building blocks and investment in people but investment in their collective voices and their collective ability to share, you know, so.

And what struck me and got me into this consumer advocacy work is that a session of people with a whole lot of different diagnoses coming together, a lot of different experiences in the system, but regardless of the diagnoses how much in common people had in terms of their experiences with access or some aspect of the service system that wasn't actually treating them in a human or a personal-centred way so I think that's the power of peer and lived experience workers right through the system is critical for showing how things can be done in different way, you know, in a way that's win/win for everybody and a lot less costly for the system as a whole if people have to, as it were, fall off the cliff before they can get the help they need.

PROF KING: Yes, I think the - I guess the parallel I'm seeing with physical health within a workplace, within a social environment, and so on it's quite common to sort of say, 'Oh, yes this person had this particular (indistinct words) open about it all', 'Yes, well, my doctor I might need that so' and then you have an open chat as well. That's a dialogue that just doesn't occur in general for mental illness.

MR LOVEGROVE: Yes, because it takes so many forms in terms of its impact I suppose. It just can't be - - -

PROF KING: But it also seems to be due to the stigma associated with, so.

MR LOVEGROVE: Yes, sure, sure. And understandably if you can avoid having to - because it's seen still as a huge weakness, there's something wrong with you, and I think that's part of the problem that the system still tends to generate. It's focusing on the problem of the person or they're the problem rather than perhaps the ways that a cookie cutter system tries to fit everyone within the same moulding like you might treat someone with - well, you don't even do that with someone with a broken leg but perhaps in much more differentiated ways that are needed to be highlighted that otherwise wouldn't be if there wasn't people with lived experience there to be supported, to be informed these systems will (indistinct).

PROF WHITEFORD: So any thoughts on what recommendations we need to make?

MR LOVEGROVE: Well, I think there should be - well, I think, you know, a whole range of peer work structures need to be supported and perhaps one I know, especially in regional areas, that brings people together with peer workers so they've got the common peer workforce support structure or that goes to things like training, mentoring, peer supervision, professional development, so that we can get a standards that everyone can also contribute to and then also get external independent support from that then through their own choices and abilities then choose to where they want to them fit within the service system so if they had an independent sort of body that they could have that support with, and there's plenty of international evidence on the power of peer support and peer advocacy and peer work in terms of really adding to the recovery and many social values and goods for other people that they can help just by being within various ways, I think would be hugely beneficial. You know, people are calling out for, 'We need to be able to do co-design and co-production' but without the structures in place to actually bring that about then people are just going to be one off cherry-picked and they won't get that critical mass to be a transforming cultural change agent that I think peer workers can be.

PROF WHITEFORD: That's great.

MS ABRAMSON: Thank you.

PROF KING: Thanks, David, thank you.

MS ABRAMSON: I think we're up to an end Stephen.

MS CHRISTIE: Thank you.

PROF KING: I'll just need you again to say your name for the transcript.

MS CHRISTIE: Yes, Julianne Christie. I just had something to add to the other conversation about the workplace and the ongoing bullying situation. One of the barriers to actually discovery these sorts of things are government entities that are self-insured.

PROF KING: Yes.

MS CHRISTIE: It is not in their interest to disclose those sorts of ongoing workplace injuries and on top of that in New South Wales, that is my experience, that people are very familiar with WorkCover as the body for physical injuries. They're not very familiar that WorkCover can also deal with mental injuries and so I think an awareness campaign around those issues of WorkCover covers physical and mental injuries would be most beneficial. But the self-insured issue where the organisation has no reason to disclose and every reason for the HR department to bury it, I think are a reporting role of doctors perhaps when they're making that diagnosis of PTSD or serious mental ill health would go away to taking away that organisation's ability to hide what's really going on. There are already mandatory reporting requirements of these health professionals and so it's probably not much of an extra ask in that in respect.

The other thing that I wanted to add was that in a two minute internet search I actually went to Scandinavia first for examples of social enterprises. They have an excellent definition of 'a social enterprise' compared to Australia. To Australia a social enterprise is basically an organisation that conducts business but it also has a social mission, whatever that may be. Sweden's definition, they actually have a work integration social enterprise, the acronym is 'WISE'. They were defined through a project that was funded under the equal program which was part of the Swedish government and they have some form of economic activity producing, selling goods and/or services. They have a primary objective of integrating people that have significant difficulties to obtain and/or keep a job in work and society which is very different to the Australian definition. They create participation for worker's ownership, contractual and other well documented means. They reinvest most of any surplus in their own activities and draw up similar activities which is what happens how, they're generally not profit - - -

MS ABRAMSON: Julianne, could I just ask one thing of you mindful of the time. The social enterprise is actually a big topic so I would really welcome if you wanted to put in a submission and to talk to us further about that because I'm just a bit hesitant to have the full conversation now because it's a big conversation and I know some of our staff actually have some questions about that so I would invite you to put a submission in and a staff member who has an interest in this might have another chat with you about it.

MS CHRISTIE: Okay, no problem.

MS ABRAMSON: Thank you.

MS CHRISTIE: The other thing that I thought of when I'd left the pressure spot, Spotless Cleaning Services is one social enterprise in Australia that is already operating on the scale.

PROF KING: Yes, that's true.

MS CHRISTIE: Thank you.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Thank you.

PROF KING: Please - - -

MS ABRAMSON: No, we should close it, Stephen.

PROF KING: Yes, you will have to be very quick because we're meant to be out of here by five.

MS LIPSCOMBE: Okay.

PROF KING: And again if you could state your name again.

MS LIPSCOMBE: Sure. My name is Joan Lipscombe. I'm a member of the (Indistinct) mental health forum but I'm not speaking on their behalf because we haven't had an opportunity to discuss your report. Now, before I comment on the report, in relation to the workplace injury and so on many (indistinct words) public servant and if we had problems we went to the union so whatever happened to them? My comments on your report are related - we did put in a submission so they are related to our submission. The submission focused mainly on physical health and the very poor statistics on the physical health of people with serious mental illness, I notice that you've got in your report the figures showing that the cost to the country, if you like, of treatment, education, housing and so on is around $43b-$53b every year.

The cost of diminished wellbeing, $130b a year of which, and I think I'm correct in saying, the substantial proportion of that is due to early premature mortality due to preventable (indistinct words). I've only looked briefly through your summary, I haven't had a chance yet to look at either of the volumes but I found comments and recommendations relating to the physical health of this group to be hard to find. Maybe I missed them but they didn't seem to prominent. (Indistinct words) the huge cost on the human, you know, personal costs. We were recently informed that the mortality rates for this group of people are worse than four indigenous people.

Now, I don't know if it's true but I was assured that by the current head of the ACT Office of Mental Health and Welfare so I think should would probably have an accurate knowledge of that information. So we did make some recommendations relating to physical health and I don't have - well, I do have them with me but I won't read them out because I refer you to them. In particular there are two which you more or less adopted but you only applied to mental health commissions and we believe, well I personally believe, that should be extended to mental health professionals in general not just mental health.

One of them related to stigma and discrimination and the other related to the funding of innovative services and new models for mental health care. We ask for physical health care with people with mental illness and integrated services where people are considered as people as a whole and not mental health here, physical health (indistinct words) so those were two that we put which I (indistinct words) look at that again in order to put a bit more emphasis on physical health care.

PROF KING: Thank you.

MS LIPSCOMBE: I've finished.

MS ABRAMSON: Thanks.

PROF WHITEFORD: Thanks.

PROF KING: And I will have to wind it up there because it's five o'clock. So thank you very much for your attendance. Let me just see, I think I have something here that I say at the end. Yes, I adjourn these proceedings and the Commissioner will resume hearings in Melbourne on 18 and 19 November so thank you very much for your attendance today.

MS ABRAMSON: Thank you.

MATTER ADJOURNED UNTIL
MONDAY 18 NOVEMBER 2019