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PUBLIC HEARING INTO MENTAL HEALTH

PROF STEPHEN KING, COMMISSIONER
MS JULIE ABRAMSON, COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

AT PAN PACIFIC PERTH, 207 ADELAIDE TERRACE, PERTH
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PROF KING: Good morning all. Welcome to the public hearings for the Productivity Commission's Inquiry into Improving Mental Health in Australia. My name is Stephen King and the presiding Commissioner on this inquiry. My fellow Commissioner who is here with me today is Julie Abramson.

Before we begin today's proceedings, I would like to acknowledge the Whadjuk people of the Noongar nation who are the traditional custodians of this land on which we are meeting, and pay respects to Elders past, present, and emerging. I extend this respect to all Aboriginal and Torres Strait Islander peoples in attendance today.

The purpose of this hearing is to facilitate public scrutiny of the Commission's work, and to receive comments and feedback on the draft report. This hearing is one of many around Australia. We are holding hearings in all states and territories, in both capital cities and regional areas. I'll get to the mobile phones in a second. We will work towards completing a final report to government in May, having considered all the evidence presented at the hearings and in submissions, as well as other informal discussions.

Submissions and comments to the Inquiry will close on 23 January. Participants and those who have registered their interest in the Inquiry will be automatically advised of the final report's release by government, which may be up to 25 parliamentary sitting days after completion.

We will conduct all hearings in a reasonably informal matter, 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 being taken. For this reason, comments from the floor cannot be taken. The transcript taken today will be made available to participants and will be available from 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 also ask participants to ensure their remarks are defamatory of other parties.

You are all free to enter and exit the room as you want, and if anyone needs a quiet space, please feel free to exit the hearing. If at any time you feel distressed or require assistance, please approach one of our staff who will assist you. Team members here can raise their hands. An at the back. In the unlikely event of an emergency requiring evacuation of the building, the exits are located out the doors to your right, near the lifts. Upon hearing the evacuation tone, please leave the building and assemble on Langley Park, which is at the foot of Hill Street, and await further instructions from hotel personnel.

The bathrooms are located back out near the lifts you came up in. Please turn your phones on silent. So An has beaten me to that bit. That includes Commissioners.

MS ABRAMSON: I am not a problem here.

PROF KING: Our first participant today is going to be a representative from Consumers of Mental Health Western Australia. I invite them to identify themselves for the purpose of the record. So Shauna, if you'd be able to state your name, your organisation, for the record, and then any opening comments you'd like to make.

MS GAEBLER: Thank you. My name is Shauna Gaebler. I'm the CEO of Consumers of Mental Health, or CoMHWA, and that's the peak body for people who have lived experience of mental health issues in WA. A recent needs analysis that we did with consultations throughout the state found that alternatives to EDs is strongly supported by WA consumers, carers, and clinicians.

The preferred models were community-based, non-clinical models featuring peer support, including safe haven cafes, and ED to home transition programs. And that's the forerunner to the importance of strengthening the peer workforce. Access to peer support was rated as the highest preferred service by over 80 per cent of consumers, carers, and service providers in the development of the alternative to ED model.

WA has a WA peer support network as a statewide network led by peer supporters to grow and advance peer support in WA. The network is a key path for industry advice and representation of peer support workers, in similar ways to a professional association. The network shows the critical importance of peer work leadership to maintaining integrity of peer work role, and to drive cultural change.

The establishment of a national peer support professional organisation must be led by and for peer workers, rather than from an external non-peer entity, including the National Mental Health Commission, government, and/or clinicians. Feedback on digital records received by CoMHWA members raised concerns on the particular privacy issues that they face. Risks for the mental health consumers relate to difficulties in accessing or using IT systems, the increased likelihood of third party control of their records, and potential consequences of stigma and discrimination.

A commitment to fund strategies are required to ensure people can access and effectively use the Internet, that they can know who is managing their records and how they can gain control of their record, and that they're provided with transparent and effective information to enable them to make informed choice and control of their digital records, and also their online participation. CoMHWA is work in supporting individuals to navigate through the mental health and other sectors demonstrates the often insurmountable service and systemic barriers that exist for people trying to access support.

Increased focus on consumer and carer outcomes and a holistic approach to our lives that is broadened beyond the health portfolio is welcome. The holistic approach needs to be reflected in a national, integrated navigation system that's for mental health consumers and community members to use, and that includes linkages to other parts of our life that impacts our mental health and wellbeing, and that includes health, financial, housing, education, and community support as examples.

It's recommended that there is a rebuild of consumer engagement to provide a robust systemic approach to collect and analyse consumer perspectives in the monitoring of mental health, wellbeing, and suicide prevention outcomes. This would capture national and state perspectives, including voices of people who tend not to be represented. A recently formed national consumer alliance of state mental health consumer bodies provides an ideal platform for gaining the diversity of consumer perspectives and engagement.

A critical component of consumers being able to access the support they need is to build the capacity of people to self-advocate on their own behalf. Investing in people with lived experience to ensure that we are equal partners in the design, evaluation and co-commissioning of services to meet the needs of consumers must be a priority. This requires commitment by the government to build the leadership capacity and skills of those that they seek to support, and not just the service providers.

PROF KING: Thank you. You mentioned a survey of consumers, I think it was, at the beginning. I'm not sure if we have a copy of that, but if we don't, we'd love to get one.

MS GAEBLER: Yes.

PROF KING: Also, just if you've got the background on the methodology and so on that you use to - in the sampling. Do you want to go first?

MS ABRAMSON: Yes, if that's all right.

PROF KING: Yes, please. Go, go.

MS ABRAMSON: I was really interested, Ms Gaebler, in what you said about data collection, because in our final report we will give some further thought to it. But obviously your membership have some serious concerns, so I'd really to understand that a bit better.

PROF KING: No, no. We were about to ask the exact same thing.

MS GAEBLER: So are you meaning - sorry. The data collection to get consumer perspectives, or?

PROF KING: Data control. Yes.

MS ABRAMSON: Data control. You talked quite a bit just then about the health records, and the concern of your members as to who has access to what, and I really want to make sure we understand those concerns.

PROF KING: Yes.

MS GAEBLER: They've been significant concerns that haven't necessarily been addressed as yet.

MS ABRAMSON: Yes.

MS GAEBLER: The issue for people who have personal experience of mental health issues is often having confidence that what is written is truly reflective. That they're aware of what's being communicated, and that the communication has very tight controls. Unfortunately, there is an assumption that people - that all of us have phones, that all of us can read our phones, that we can comprehend documents and manipulate through the complex process of - I don't know whether you've tried, but getting onto My Health Record is a complex system to be able to control.

So people don't necessarily have access to the internet. They don't necessarily have phones that they use, and there's a reasonable number of people who also can't comprehend and take on, as I say, some certainly clinical, complex documents. Those issues haven't yet been addressed. What do you do with people who can't access or comprehend any digital records or online participation? The answer from ADHA was to use a public library, which is obviously not appropriate when you're looking at very sensitive data.

So what do you do for people who can't access or have difficulty being able to fully engage. Having control over the information, the people who have a history, an experience with mental health issues, are more likely to have guardians, to have limited control of access, and to have information that's uploaded which they don't necessarily even know has been uploaded. There are assumptions there. I guess the important part is about having a system where people can be really listened to, and that hasn't happened as yet.

There has been a big push to get online systems up and running that are now with us, and still we have people that don't know what they are, and they - we have, for example, people who are residents in psychiatric hostels who are asking us how do I - what is it, and how do I get control of it? And there's no one that we actually get to help with that.

MS ABRAMSON: One of the things that the Commission has been thinking about, but in a different context, is non-legal advocacy to support people with mental ill-health, and also the peer workforce. From what you're saying, that might be an area that we could look further for providing the gateway or the support for what you're talking about.

MS GAEBLER: I think it needs to be proactive, as well as reactive. Sometimes the advocacy services are dependent on people contacting you.

MS ABRAMSON: Coming. Yes.

MS GAEBLER: From our perspective, we would strongly support having peer support. So having it so that it's - it's a different relationship. All of the people who are at CoMHWA are peers and there is an increased likelihood of a trusting relationship where you could have equal communication. So that in itself can help de-bureaucratise, for want of a better word, and make it that people are more likely to come. And sometimes the conversation can be enough.

MS ABRAMSON: I might have this wrong. Is there any demographic issue? Are younger people more inclined to use computers, et cetera, or is just the nature of people's mental illness?

MS GAEBLER: Well, I think it depends on what aspects you're talking about. There's an across the board concern with what goes into documents. As far as managing it, when people are unwell, that can be difficult, whatever age that they are. Certainly, as with everyone, there's a higher likelihood for people who are older, but poverty affects people across the board, and that can also be a major issue for people.

And people's confidence, there can be disconnect at any age with an online system, and I think working with people on when it's appropriate and how they would say, actually, that's not right for me, if it's been set up on the assumption that if you live in X place, then you will only have online access or - so how you work with people to actually mean that we can actually support people.

MS ABRAMSON: No, I understand. Thank you.

PROF KING: It was interesting that we both were about to focus on data. I'm going to come back from a slightly different on the data, and back to the issue of control. And My Health Record is an example of, perhaps a system, but I personally think could have been designed a bit better because, of course, it's not controlled by the consumer. It's the situation where if practitioners, clinicians decide not to upload your data, then your data doesn't get uploaded even if you want it uploaded.

So I'd be interested in your thoughts about making sure that consumers have control of their complete health records, and potentially not just clinical records, but it may also include records of relevant psychosocial supports. Have you got any thoughts about the gaps there? What we should be recommending to make sure that the system works for the consumers?

MS GAEBLER: One of the concerning aspects, again that hasn't been addressed, is around what gets uploaded. So for all of us who have My Health Record, it's not at the forefront of our mind. Many people have never looked at it, and anyone can upload anything at any time, and you are unaware, and often people are surprised, if they end up going on it at some stage to see what has been uploaded.

So the idea you can control it doesn't work if you don't even know that something's there, and then going through the process, well something's up there that I don't want, or I don't agree with, then what do you actually do about it? And I wouldn't have a ready answer for that, and I've been around My Health Record now for a long time. So how get control, a lot of it is around letting people know, but also having support for people.

So, as I say, what do you do if people are in psychiatric hostels? Who do they go to? Who do they ring? Or who do they - and often they need someone who can stand beside them to help them to get control and explain what it means and how they keep it going, and you can get control that gets overridden at various times, so how do you get that back? What happens if you have an authorised representative for a period of time? What rights do you have if you've got an authorised representative?

So there's lots of different aspects, but a lot of it is around an acknowledgement by the government that there has been major change, and it's been done without taking people along with them. One of things is around - is domestic violence, for example, that we've been working with the ADHA and trying to get that so that there's a system for people who are at risk which raises - like mental health issues can do - the privacy issues and control and informing, all of that isn't yet - is up there, but isn't yet sorted.

PROF KING: Over a coffee, I'll tell you how you get information removed, because I know somebody who had completely false information up there, because she happened to have the same name as another client, and the clinician had happily uploaded it to the wrong person.

MS GAEBLER: Wow.

PROF KING: So, yes, I'm not sure how robust those records are. One of the issues that has come up at a number of occasions is the issue of carers versus consumers. So it can be situation that there are situations of formal guardianship, but there are also situations where legitimate and well-meaning carers feel that they should have certain rights. For example, relating to consumer's health data and being informed. I'd like your views on that, and how do we balance the issues of rights and what carers see as trying to do the right thing.

MS GAEBLER: There are tensions. We work in partnership often with various carer bodies, but there are variances, and we know that there are times when there will be quite a significant variance between what - people want to have personal experience of mental health issues, and what their family or carers also want. From our perspective, it's a matter of - from our perspective, it's a matter of listening to people who have the lived experience of mental health issues, and then in liaison with, or it's just the leadership of those people who have mental health issues to be able to start formulating processes.

So there is an assumption. I mean, one of the things that is an example is people may believe that they are the family and carers who are the primary source who - but when you speak to people, that's not who they see, and in fact, sometimes they're the problem with them.

MS ABRAMSON: One of the solutions that has been put to us, again in a slightly different context, is advanced statements. So that somebody could actually elect to do exactly what you said. I mean, we used to have that with superannuation. People would say, but that's not who I want to assign my super to. So the advanced statements is something that we'll have a bit more of a look at.

MS GAEBLER: It depends where someone - the other thing is it can be a fluid - a fluid state. So the difficulty with something like that is it becomes - - -

MS ABRAMSON: It's locked into their super.

MS GAEBLER: Yes. It then becomes an assumption that things haven't changed.

MS ABRAMSON: Yes.

MS GAEBLER: There is within the national Standards, for example, the National Mental Health Standards, some incongruity between the consumer rights and carer rights. So there is some greyness between, and from our perspective, it's - it is something that there are differences. There are organisations that have carers and consumers in there, and there's a lot of things that - the alternatives to ED is a good example, where there's actually great congruence between.

But then there are other issues where there can be different views, but also some, I guess, information not being shared because people don't want to hurt their family members, if the talk is around suicide prevention, for example. You can have different conversations. So we'll often have a joint conversation, and then we'll have a split conversation, and carer, peers, we'll talk with carers and we will speak to consumers, and then be able to get some - the mixture of the views into whatever decision is being made.

PROF KING: Just one last one from me, is you mentioned self-advocacy, co-design, getting a lot more consumer input into the services that will be - are supposed to be meeting the consumer need. And we say several things in our draft report, but there's then the issue of exactly how do you go about that. So what are the practical, on the ground recommendations that you think we need to make around co-design so that, rather than just being statements, we're able to move this forward. What do you want us to tell government?

MS GAEBLER: That it's a complex system. That there isn't an easy answer that I can give you. That there are those groups that are more experienced in doing it. From our perspective, we use multiple methods.

PROF KING: Okay.

MS GAEBLER: So it is around supporting people at various levels to be able to have input. So, for those people to self-advocate, to even be able to start conversations on their own support requirements, through to the executive level of people who can influence and sit at tables with decision-makers, all through it needs to be informed, and I'm really aware of those people who don't sit at the table, but who can have really important perspectives.

So how do you capture that? And the work that we've done, the surveys for example, were - the methods were specifically targeting certain groups, and then also the more generic, and then also the consumer, carer, service provider. So there's different strategies, and for that, it's a matter for the government to fund. So it needs an investment in order to be meaningful. The representation can be still tokenistic. It can be having one person sitting at the table who speaks of behalf of everybody, but who actually isn't funded to be able to achieve that. So it's an impossible task that people are set up with.

The mechanisms, I'm really happy to speak in more detail on the mechanisms that can be used, and the resources that are out there. Certainly the national structure that we're just developing is based on consumer peak bodies at a local level, and that's about really trying to get a system for the voice that actually works, that isn't just a group in Canberra, that is based in reality. But also it goes through an analysis process that's equally important so that you have consumers analysing the result. So it doesn't go through collecting a whole lot of information that then goes into a bureaucratic lens and gets massaged into what people think is what that - those statements say.

So it is a continuum process that has got more maturity now, but actually has, I think, poorer penetration than it should have. So I think it can actually be increased focus for the Productivity Commission report, because I think it's easy to look at that and still think, okay, I'll have a consumer at the table, and then we'll go away and we'll develop the report that would then - it will mean that the consumer voice becomes one of many of other stakeholders and it will tend to be overridden, and it will also be interpreted by somebody else.

PROF KING: That's right, yes.

MS ABRAMSON: We're very interested. I don't know if you intend to make a further submission to us. We are very interested in what you had to say then, and a number of the sort of warnings you gave us about how it could be done. That would be really helpful.

MS GAEBLER: Okay.

PROF KING: That would be fantastic, if you could. Are you finished?

MS ABRAMSON: The only other thing I wanted to ask was about rural and remote communities, and my colleagues, Stephen and the team were in Geraldton yesterday, and people spoke to us about the lack of services. So I'm just really interested in your perspectives, bearing in mind we talked about data and online, and online was one of the ways we thought we could get some services to regional Australia. So just interested in your views.

MS GAEBLER: It's a perennial problem. One of the issues is around transport, and that's one that isn't well picked up by anybody. NDIS has really highlighted problems in regional areas, and I think that that's going to continue to have influence. There's certainly feedback we're getting from service providers that their commitment to certain regional areas isn't long-term, and that they will be pulling out or reducing service - services' availability in regional areas.

So certainly looking at what can be done at a regional level, and what - again, a lot of it comes back to how you speak to people, and what will work within their region, but also from a business perspective, and how you make things viable. So you get buy-in from people. If transport is an issue, then that needs to be addressed. So how do people get to appointments - - -

MS ABRAMSON: The services.

MS GAEBLER: - - - if they don't drive, if they don't have access. There often isn't the public transport that's from where they live to where the service may actually be there, but they can't access it.

MS ABRAMSON: Thank you.

PROF KING: Thank you very much.

MS GAEBLER: Thank you.

MS ABRAMSON: Thank you.

PROF KING: Yes, I'll excuse myself now. So, I'm now going to pass over to Ms Abramson to chair, because I do have a meeting I have to go to for a short period of time. I will return later on this morning. So Julie, if I can leave it to you.

MS ABRAMSON: Thank you. Could I ask if HBF Health, Professor Hugh Dawkins. Professor Dawkins, if you'd be kind enough to state your name for the record, and the organisation which you represent.

MR DAWKINS: Yes. Hugh Dawkins, and the organisation, HBF Health.

MS ABRAMSON: And I'm assuming you have an opening statement.

MR DAWKINS: And I have a colleague joining me.

MS WALKER: Lynne Walker, HBF Health.

MS ABRAMSON: Thank you, Lynne.

MR DAWKINS: Well, we do have a - we indicated that we're more than interested in the report, that we are wanting to be active and proactive in the space of mental health as a - and I'll probably have to backtrack in a minute, but as a large private health insurer in Western Australia, and with a national footprint, we are very interested in the journey of people who are living with mental health and how to improve that journey in what is a complex health system, particularly at a time when you may be under greater stress or experiencing also mental health issues and other health issues concurrently.

In particular, we feel that the areas where we are probably most aligned and would spend our time talking to you is in Reform area 2, closing the critical gaps in the healthcare services, and also in Reform area 5, the fundamental reform of care coordination, governance and funding arrangements. While we can't really influence legislative arrangements, other than through peak bodies such as the Primary Health Alliance, or association, we can actually - we are interested in how our products, if you like, our health services and our pathways can actually better support, enable, and empower people who are living with mental health issues, and also with other concurrent health problems.

UNIDENTIFIED SPEAKER: Excuse me. Could we ask you to speak up, please?

MR DAWKINS: Sorry.

UNIDENTIFIED SPEAKER: It's really soft down the back.

MR DAWKINS: Sorry, I thought the mike - - -

MS ABRAMSON: I should explain, the microphones are not for amplification.

MR DAWKINS: Okay. I'm sorry about that.

MS ABRAMSON: They're actually for the transcript.

MR DAWKINS: Is there anything in particular you would like me to - - -

MS ABRAMSON: Excuse me, I'm so sorry, Professor Dawkins, but we can't take questions from the floor.

MR DAWKINS: We can't answer. Yes. No, that's all right. I appreciate that.

MS ABRAMSON: But we do have people have an opportunity when they're called to give submissions.

MR DAWKINS: Sure.

MS ABRAMSON: Could I ask you two questions, if that - or did you have something else?

MR DAWKINS: No, no, no. That was just some overarching - - -

MS ABRAMSON: What services are you providing now, is the first part, and the second part is, what would you like to be providing, but the regulatory system or whatever does not support you to do that? So dealing with the first one, what type of services are you providing at the moment?

MR DAWKINS: So I might - - -

MS WALKER: Do you want me to come up there?

MR DAWKINS: Yes.

MS WALKER: So we're currently providing admitted hospital services. So overnight admissions and same day programs. That's on the hospital product. And then on the general treatment product, in the outpatient setting, we're offering services for psychologists, clinical psychologists. So I guess that less acute services, but under the general treatment product.

MS ABRAMSON: So with the psychologists, is - you're offering a gap payment?

MS WALKER: Yes. There would be gaps there, and I guess with the admitted services, there will be no gaps. And so we do have a - a sort of grey area between admission and outpatient, where there's a sort of, I guess a perverse incentive to not have the right care in the right setting in the right place.

MS ABRAMSON: We're very interested in having this conversation with you, because you will have noted in our draft report, we're very keen for health funds to be able to do more in a community setting.

MS WALKER: Yes.

MR DAWKINS: Yes.

MS ABRAMSON: So just how that might look like from your perspective, if you didn't have these legislative restraints, what type of services would you look to provide?

MS WALKER: Well, I guess we would put the patient first, and work out what's the best pathway for the patient, and then the funds would work around our product really, I guess, to make sure that the right care had been provided in the right time in the right place, but also under the right product, to make sure that it's financially viable as well.

MS ABRAMSON: Would you anticipate, and you may not have an answer to this, but would part of that be you having preferred providers in the way that you do in other areas?

MS WALKER: It could be. Yes. I mean, we have preferred providers in the admitted setting. Like we have contracts with the providers. Less so in the general treatment space, but yes, that may be that would have to - to maybe - to offer a no gap solution, and I do feel that we have to look at potentially no gap solutions if they're a hospital substitute. Then yes, we may have to have a preferred provider arrangement, like we do with the dentists and optical providers. That could be a way forward, yes. That would allow us an element of comfort in the sort of exposure.

MS ABRAMSON: How does your current funding model work with hospital admissions? You, I assume, provide a certain number of days at a certain rate.

MS WALKER: Yes.

MS ABRAMSON: I know all the hospitals have (indistinct).

MS WALKER: Yes. Under the hospital product, you can have limits. We're not allowed to have any limits, so we can't then say, well, you're allowed 20 days stay. That's not possible. Under the patient setting you can. So there's no limit, so with regards to length of stay, we do have industry guidelines that determine what an admission should look like.

So basically, that sort of highlight the acuity of the patient that would be required for an admission, for example, and they're industry agreed guidelines, and they tend to sit in the contracts to make sure that the hospitals abide by those rulings, and are auditable, I guess. But yes, hence there are no limits, so we do have to make sure that the right patient is in the right setting.

MS ABRAMSON: Just in terms of the care pathways, care coordination, I'm making an assumption here that if you could do more in the community, those are exactly the type of areas you'd be interested in.

MR DAWKINS: Yes.

MS WALKER: That's right.

MR DAWKINS: Yes, exactly. Right setting, right place, right space. We're conscious that many of our members, we talk about our members, but in actual fact we - I mean, some of the service - we are interested in the wider health picture, beyond our members. We're a very long-serving institution in Western Australia and feel a great sense of responsibility to the wider population.

So, in terms of getting back to your question, yes, it's about a very person centred approach and recognising that frequently mental health issues do not occur in isolation, and there are a whole lot of other contributing factors, and we actually want to be there and to be part of the pathways and solution. We want to empower our members and the people with greater control over their choices.

MS ABRAMSON: What does that look like if - you know, in a practical way, what would that mean?

MR DAWKINS: Just options, clearer options, and perhaps offering health navigation through the process. Everybody talks about health being complex. It is actually also complex for people in the health services, to understand where to go, and I can give examples of people who are very experienced in health, and when they have their own health issues, they say the biggest problem was navigating the health system. And so we feel that we could actually offer trusted navigation for members through the system.

MS ABRAMSON: Would you think that that would look like something like CancerCare that's provided now? A number of the hospitals run a very integrated level of care. So is that the type of service you're thinking of?

MR DAWKINS: Yes, yes.

MS WALKER: Essentially. Yes, I mean, we're exploring similar solutions in other areas. So I guess that could be replicated.

MR DAWKINS: Yes, that's right. We're looking for things that work, and to be pragmatic how to assemble them in order to further help inform, and to make sure that the patient outcomes are actually - are improved, as well as their - - -

MS WALKER: Experiences.

MR DAWKINS: - - - their experience with the system.

MS ABRAMSON: Can I ask, along those lines, we had a submission just before about consumer participation. So, in terms of developing your model, should the legislative arrangements be changed? How would you work with the consumer and carer groups?

MR DAWKINS: I have a long history in working with the consumer and the carer groups. In particular, I have found in the past that in writing pathways, developing pathways and writing policy around healthcare that the consumer voice is extremely powerful and, in fact, it often helps to enable the policy to the written in a way that can be better enacted. I have seen that the consumer voice often exceeds the academic and bureaucratic solutions because they recognise the problems and they say, we understand these problems, and here is what we're prepared to accept.

So they provide that - the trade-offs they're prepared to make in order to achieve a good outcome.

MS ABRAMSON: Do you have mechanisms already which deal with that?

MR DAWKINS: HBF doesn't, at this stage, have those mechanisms. That's something that I bring from some of my previous roles.

MS ABRAMSON: Also, we're very interested in overseas experience. So any models of care from overseas that you're aware of?

MR DAWKINS: We are in the early stages of exploring some of the European models. We find that they're very useful, because they deal with multiple cultures and differences, and we think that has a - has a setting, and there are also some of the large providers of private health insurance in the US that have reasonable models that we think could be adapted and adopted into an Australian setting.

MS ABRAMSON: I'm pressing a bit, because we're really interested in this.

MR DAWKINS: Yes.

MS ABRAMSON: What sort of aspects of that model of care? Because the American system is very different from the Australian system.

MR DAWKINS: Well, it is, but the interesting thing is, by focusing on the person, it's the patient needs that actually is the unifying factor in all of those scenarios. I don't wish to be vague, but we would pragmatically picking the key points and the key enablers out of the systems, and then would be wanting to test it with the - with local voice, people who have lived experience or who are organisations that support people with mental health. I would also like to add that part - and I mentioned it in some of my opening comments, part of the conversation we're having within HBF is the fact that mental health issues sometimes appear at the same as a further health crisis.

MS ABRAMSON: A comorbidity, yes.

MR DAWKINS: Yes, and it's the comorbidity, it's the concurrence, and not only for the person with the illness, but for their loved ones, or for siblings, and so there's a ripple effect. And we're wanting to be cognisant of that time and of that pressure. But also, from a medical and a hospital discharge perspective, we discharge people because the reason they were admitted has now been fixed, or is in remission, not then taking into account that there are longstanding and perhaps anxieties and potential mental health issues that are still stemming from, or underpinning some of the aspects of their recovery.

And so, we're wanting to - when I say we're wanting to be person centred, it really is about the whole person; their physical wellness and their mental health and wellbeing.

MS ABRAMSON: Just on that point, would you see yourself having links with other providers there, and the point about discharge from hospital, from ED, has been quite a concern for the Productivity Commission, because it's really about making sure that people are discharged with access to other services. So you talked before about navigation, so is that an area where you would expect to be able to assist your consumers with linking to other services?

MR DAWKINS: That is very much an area where we'd like to do it. Our Chief Executive Officer is on record of often saying, you know, as a private health insurer, we can pay for physiotherapy, we can pay for occupational therapy.

MS ABRAMSON: Yes.

MR DAWKINS: But in actual fact, we can't engage general practice, which may be in terms of a medical anchor point or navigation point for people at discharge. It would be nice for us to be able to have this continuum of care through hospital and perhaps some sort of – our response into general practice. We recognise that this is complex, and may – and has health and cost implications for all parties.

MS ABRAMSON: And in fact, under our model, we propose that we would have a pooling of resources of a regional commissioning – so we've got two models. That's our rebuild model, but the renovate centres around the PHNs. But I guess what you're saying to us is until you're able to work more within the community settings, your relationship with GPs is not going to be a direct one, because you cover hospital and ancillary expenses.

MR DAWKINS: Yes, yes.

MS WALKER: That's right.

MR DAWKINS: If you're familiar with Auskick, they - - -

MS ABRAMSON: I'm very familiar with Auskick on a Saturday morning.

MR DAWKINS: Yes, so they lay down ropes, and the children can run up to the rope, and then they have to stop chasing the ball.

MS ABRAMSON: Yes.

MR DAWKINS: And we sometimes feel like we're playing in you know, a bit of an Auskick game, in that there are – the rules sometimes are an impediment to managing – helping us to manage the patient journey.

MS ABRAMSON: No, I understand. I'd also like to ask you a bit about stigma and insurance. Now I know you can't talk to me about general insurance, but we've had a lot of submissions around stigma, and people being unwilling to disclose. Now in an insurance setting, that's been put to us in other types of insurance.

MR DAWKINS: Yes, yes.

MS ABRAMSON: But I'm really interested in your views about how we can do more to educate people, and sort of your corporate view around some of those issues.

MR DAWKINS: Yes. Lynne may want to add a little bit more to this, but one of the issues is people don't – and have difficulty distinguishing between general insurance and life insurance, and health insurance, and the fact that health insurance is community rated.

MS ABRAMSON: Yes.

MR DAWKINS: So everybody who appears gets the same rating.

MS ABRAMSON: Yes.

MR DAWKINS: But it's a difficult concept, and it's difficult for people to sort of get their head around the fact that this is quite a different insurance policy. So I believe that yes, there is a lot of need for improving our understanding, and improving – and make clear a message that private health insurance is a community rated program. That also is another one of the impediments, I believe, to some of the new technology and the new knowledge that we think we could bring to the space, is the fact that people might feel – that private health members might feel that this was – had a potential to discriminate or to identify them in some particular manner, where in actual fact it would be very useful in helping to manage their treatment, or some of the pharmaceuticals that might actually be of benefit to them.

MS ABRAMSON: And you know, I probably show my ignorance of the health system without my fellow commissioner here, but the only way someone's pre-existing mental illness would be relevant to you would be in a cover period, when someone's changing insurance, I gather.

MS WALKER: Yes, yes.

MS ABRAMSON: Because you can't not insure them.

MS WALKER: When they're new. That's right, when they're new to – when they're a newly acquired member, yes.

MR DAWKINS: Yes.

MS WALKER: There's a waiting period. That would be the only time. But also for - the reforms now allow younger persons to upgrade without having to serve their waiting periods, so that barrier's been removed as well.

MR DAWKINS: And is it true that somebody who's going from one insurance policy, if they're moving to another - - -

MS WALKER: Yes.

MR DAWKINS: - - - provider, and a similar policy - - -

MS WALKER: And if they've served their waiting periods.

MR DAWKINS: Yes, yes.

MS WALKER: Yes, they continue on the portability rules, yes.

MR DAWKINS: So the conditions travel with them.

MS WALKER: Yes, yes.

MS ABRAMSON: Was there anything else that you'd like to add?

MR DAWKINS: Could I just make one comment - - -

MS ABRAMSON: Absolutely.

MR DAWKINS: In relation to remote and regional areas.

MS ABRAMSON: Yes, yes.

MR DAWKINS: I noted in the previous one, your very interest in that.

MS ABRAMSON: Yes.

MR DAWKINS: The Aboriginal – and in terms of access and people not having to travel too far, the Aboriginal Health Council of Western Australia is establishing a web-based system called Mappa, which is mapping care closer to home. And the premise of it is that nobody knew what services, outpatient or outreach services, were occurring in different settings and at different times, and so people would often travel all the way to Perth to get treatment when in actual fact, there would be a clinical group coming up that would be able to provide adequate care closer to home, or provide some support closer to home.

And so that is a very large project that they are running, and again, it is being run by the Aboriginal Health Council, but in actual – the tool and the platform is available and would be rolled out for all people in remote and regional areas. There's Telehealth components, there are components where communities put in about ceremony and law time, about the drivability of the roads, and other access issues. And it's already been – I say trialled, it's already been conceptually implemented between Royal Perth and about 15 communities, and it is enabling the hospitals better information about discharge, because they know what is going to be available in the local setting that they're discharging the patients to.

MS ABRAMSON: We would be – I'm not sure if you were intending to make a formal submission, but we would very much welcome one, especially around your interest in doing more in the community, but for some of the barriers in relation to that, would be very helpful for us.

MR DAWKINS: Okay, thank you.

MS ABRAMSON: So thank you very much for your time.

MS WALKER: Thank you.

MR DAWKINS: Well thank you very much, and we greatly appreciate having had an opportunity to contribute.

MS WALKER: Thank you.

MS ABRAMSON: Our next person we have is Mr Calleja from St Bart's. I hope I've pronounced your name properly.

MR CALLEJA: It's close enough. Calleja.

MS ABRAMSON: Calleja, sorry. If you could announce who you are and who you represent for the purposes of the transcript.

MR CALLEJA: Okay.

MS ABRAMSON: And I'm assuming you may have an opening statement you wish to make.

MR CALLEJA: I have, yes, thank you.

MS ABRAMSON: Thank you.

MR CALLEJA: Thank you for the opportunity to make the submission. My name is Joe Calleja. I'm a qualified social worker and life member of the Australian College of Social Work, currently interim CEO of St Bart's. I've held positions as principal social worker in the child protection department in this state, executive manager for family relationship counselling service, senior executive service and justice, and more recently was the CEO of Richmond Fellowship WA, which is now called Richmond Wellbeing. It's a nongovernment agency which provides community and residential support to people with complex mental health difficulties.

I resigned three years ago, but I'm working with a number of agencies on improving their focus to mental health recovery, and I'm currently with St Bart's, which specialises in homelessness, aged care and mental health. And the Commission has clearly undertaken an enormous amount of research and consideration in the preparation of the report, which has been released for public comment.

Mental health and suicide are significant social and emotional wellbeing issues, which have a profound impact in personal as well as economic terms, and the work of the Commission in this regard has the potential of making a very significant impact in future government policy across government, not just in the health sector. The report is complex and hard to respond to, so I've grouped my comments broadly rather than try and respond to the many recommendations.

Although there are some very insightful and helpful recommendations in the report, the key assumption on which the report is based, and that is treatment within the clinical system is the basis for a person's recovery is very contestable, and that assumption has resulted in the report being written in a way that has the potential to set back many recovery focus gains made by consumers, family members and non-government agencies in the mental health sector over the years.

The assumption suggests that the Productivity Commission has not heard what has been said about recovery, nor has it been proactive in informing itself, but instead has opted to assume the status quo is sound, and has tinkered around the edges in recognition of the role of social determinants and the importance of prevention and early intervention. A significant omission in the Productivity Commission report is the failure to mention the child protection system. This is disturbing, as so much attention is paid to the role of schools and early intervention for children and young people in the report, which is good comment.

But children in the child protection system, particularly those in care, are often traumatised both by their family experiences, as well as by the intervention of the state. They spend six hours a day in school with other children, and they are often likely to be bullied or to bully, and are often visible in class as problem behaviours. These issues alone, I would have thought, might be recognised in the report, but more importantly, I would have thought that their general need for wellbeing would be explored. It seems to have either been forgotten by the Productivity Commission, or the Commission has wrongly assumed that because they are in the care of the state, that their key needs are being met. This is a fundamentally unsound assumption.

I would have thought that the Productivity Commission would have had both an ethical and moral responsibility to proactively inform itself, rather than assume that the current health system should remain the basis of what should be provided in the future. If the Productivity Commission has spoken to consumers, family members and nongovernment agencies, it has only just listened, but probably not heard their concerns, if it assumes that the current deficit-based treatment approach of the health system should remain as the core of future mental health policy and service directions.

So today I'd like to briefly focus on four issues: the first is the assumption on which the report is based, and that is that clinical intervention should be the primary response; the second is that I believe there is a lack of genuine engagement with the lived experience; the third is there is a clear failure to understand the importance of psychosocial support; and the fourth is that the assumption that the current dominant research approach in mental health and suicide prevention are genuinely able to inform future directions.

So the draft report, in my view, has the potential to entrench the current medicalisation of the mental health system, even in spite of the recommendations which recommend or recognise the importance of addressing the social determinants of health, and that is good to see those in there. However, if in its current form it continues, it will simply further disempower consumers and family members, and also reduce the capacity of the nongovernment sector to help people in their journey of recovery. It will consolidate the power differential between consumers, family members and professionals, in which professionals, not the person in particular, are placed at the centre.

And so the first proposal for consideration is to change the assumption on which the report is based. The response by health professionals to mental health difficulties is based on the belief that a person is sick or has a biological basis to their diagnosed condition. A whole industry has emerged in which people are categorised and treated using so called "evidence" based approaches, such as the increasingly discredited DSM-5, and the momentum in perceiving people as being sick as opposed to distressed has also been accelerated through the efforts of the pharmaceutical industry.

Many people with mental health difficulties have developed serious physical health problems because of the over-prescribing of drugs, yet their level of distress has not necessarily been mitigated. This hearing isn't a forum in which these issues can be actively discussed, and I recognise that. However, I would draw to the attention of the Productivity Commission the work of ImROC, that's I-m-R-O-C, in Nottingham in the United Kingdom, where a cross-section of government and nongovernment agencies have for the past several years worked together to achieve organisational change that enables their system to assist people in their recovery without it being viewed from a deficit base.

I would urge the Productivity Commission to adopt their key focus around thought leadership in mental health, which is our role is to create an environment where recovery concepts, leadership and practice can thrive in the long term. Our ambition with all clients is to enable self-sustainability. Unfortunately the draft paper of the Productivity Commission, if its key foundation is carried forward, will have the opposite effect to that statement.

In my submission to the Productivity Commission in April this year, I also cited the work of Rachel Perkins OBE from the UK, who is involved with the ImROC, and whose own articles on peer support with ImROC's publications would, I believe, greatly assist the Productivity Commission achieve a more balanced report about future direction of mental health in Australia.

Further to that, the West Australian government has begun to take the lead in Australia in introducing recovery colleges, which adopt an educational approach that allows service providers and the lived experience to jointly understand what works best to support recovery in individuals. Recovery colleges were first established by Rachel Perkins in the UK when she introduced one in her national health trust. The WA government is in the process of establishing a network in WA, and further information on that can be obtained from the mental health commission. Initiatives such as recovery colleges can help break down some of the power differentials that currently exist at an individual level within the system, and may assist at a broader, systemic level.

So I want to move on now to comment about the lack of – perceived lack of engagement with lived experience. There's evidence of some understanding about recovery and lived experience in the report. However, in my view, it is peripheral in comparison to the overarching message that at the end of the day, professionals know best. There is some recognition of the value of peer support, but it is still through the eyes of there being present a clinically dominated workforce. The Productivity Commission, I don't believe, has recognised that peer support can occur without the presence of clinicians.

Initiatives such as the Hearing Voices Network are peer support groups which are not clinician led, or clinician engaged. They are run solely by peers and have been found to be extremely effective in building hope and confidence, and enabling people to take more control of their lives. Participants might still take medication and see their clinician. This isn't about either/or, it's about another. But they also have this space with peers, which is their own space, and allows them to build confidence and to take control over their voices, which are real to them.

A similar approach is emerging in suicide prevention, where peer support groups that do not involve clinicians are being set up in Australia based on the Alternatives to Suicide approach from the Western Mass in the US. They're founded on the same principles as the Hearing Voices Group. These peer to peer approaches are initially met with considerable resistance by the traditional clinical-based system, but they will gradually be accepted.

In 2005, I introduced the Hearing Voices approach to Australia from Europe, when I was at Richmond Fellowship, and now you can find them both in the public and nongovernment mental health system, but they were strongly resisted initially. They are now part of a bigger research agenda in mental health. I'm part of a group in Western Australia that are introducing the Alternatives to Suicide peer to peer support, and there's a group for trans TransFolk people that has been running successfully in Perth since May 2018 without any clinical intervention, and there are plans to run Train the Trainer programs in Perth, Brisbane and Sydney in 2020.

But returning more specifically to the broader issue of peer engagement, whether it be individuals or family, I believe the Productivity Commission needs to recognise that the lived experience is not an organised block like the AMA College of Psychiatrists, or the Nursing Federation. So the Productivity Commission needs to reach out to these groups, which are dispersed, if it genuinely wishes to reflect their thoughts in developing a future strategy around mental health in Australia.

I believe the Commission needs to recognise that the lived experience in all areas has had to contend with negative messages about their value and knowledge for many years. So they often have to overcome the hurdle of not even feeling confident to express their views for fear of being shot down by professionals who claim to know what they think. I think it is imperative for the Productivity Commission to reach out in whatever way it can to more fully understand the needs of the issues of lived experience.

I want to now move on to psychosocial support, which is the third point. For whatever reason, the Productivity Commission has formed the view that psychosocial support really only becomes required when the treatment system fails. This assumption goes to the core of why the Productivity Commission in those areas is seriously flawed. Psychosocial support is about a person being able to be included in the community and to have a life worth living. It is there throughout the person's journey of recovery.

Good psychosocial support is more likely to help a person in their recovery than clinical intervention or drugs, but it's not an either/or arrangement. It seems the Productivity Commission sees NDIS as a benchmark for psychosocial support, and somewhat curiously suggests NDIS should be the sole provider of this at the Commonwealth level.

I would like to remind the Productivity Commission that the Productivity Commission report, which created the NDIS, had only 10 pages in a thousand page report about mental health. The NDIS has had disastrous consequences for many people who have mental health difficulties because of the closure of (indistinct) and the reframing of partners in recovery. As many people who are receiving psychosocial support from those services have lost it, and are not eligible for NDIS.

I recall some years back a statement by a consumer who said, "I have spent years trying to prove I am recovering, but now to be eligible for NDIS, I have to say I'm permanently ill." So I hope the Productivity Commission will revisit its view of psychosocial support to be a much broader intervention than a post-treatment failure.

The nongovernment agencies across Australia provide thousands of people with psychosocial support to help them live a more fulfilling life in the community, and research from overseas shows that where people have had personal budgets, they spend very little on clinical intervention. Instead, they would purchase gym membership, education, driving lessons, and related local community activities that help them live a normal life in the community. So in between their 30 minute monthly appointment with their psychiatrist or case manager, they have a life to live, and psychosocial support assists them to lead that life.

And this leads me to my last point, which is about research. The Productivity Commission report could benefit by accessing broader research base, which reveals more of the social contributors to the understanding of mental health difficulties, instead of relying on research which is deficit-focused and perpetuates an illness perspective, rather than understanding the trauma basis of distress. I mentioned earlier the link to more closely related research with the lived experience. I want to spend a little time looking at research which draws on the strong links between early trauma and distress in later life. I believe this research helps us to understand why concentrating on risk assessment in suicide, for example, rather than understanding what's happened in people's lives, is not helping our current suicide or mental health prevention.

And I draw your attention to the research by Vincent Felitti, who created a clinic for chronically obese patients at Kaiser hospital in San Diego, and he noticed a high dropout, almost exclusively limited to people who were losing weight successfully. In his review of one patient who had lost significant weight and then put it back on, he was told that the heightened interest in her by men after her weight loss triggered her action in putting weight back on, as she had a history of sexual abuse.

So the further exploration with other patients revealed that they were using obesity as a solution to deeper problems, and it's this adverse child experiences research, the ACEs research, which I would draw to the attention of the Productivity Commission to inform its further research agenda. I won't go into more detail about that research, but I would like again to thank the Productivity Commission for the opportunity to speak, and I hope there will be an increased focus by the Productivity Commission in broadening the basis on which it builds its final report, and that this will include strengthening the perspective of the lived experience, and an increased understanding of recovery, and an increased understanding of the role played by psychosocial support.

MS ABRAMSON: Well thank you for outlining that. One of the things that I'd ask you in terms of the priorities, which are the areas that you say – I mean I understood what you've said to us – are the priority areas? So we talked a bit about psychosocial supports, so I'm just interested in understanding in the list of things that you've articulated to us, where you would see us prioritising our attention.

MR CALLEJA: Sure. I think in terms of language of the report, it needs to be rewritten from a strengths base, rather than referring to mental illness and so on. In relation to psychosocial support, I think the report needs to actually step away from referring to psychosocial support as being post-treatment failure, to being a foundational approach to the future reform of the mental health system. And that does include a recognition of a stronger partnership between the nongovernment sector and the government sector, with the consumer in the middle and recognising carers and families are part of that strong support network for consumers.

MS ABRAMSON: We have spoken to a lot of consumers and carers in the course of the report. I've understood what you said. I mean you'd understand our perspective.

MR CALLEJA: Sure, yes.

MS ABRAMSON: It would be contestable, but I'm grateful that you've come today to talk about these issues. So in terms of consumer participation in the system as a whole, we've spoken a little bit this morning about what that might look like. So I'm really interested in your recommendations about how you would include that voice.

MR CALLEJA: The voice would be included in future research.

MS ABRAMSON: Yes.

MR CALLEJA: I think at the moment, most research that engages consumers or lived experience is fairly tokenistic. It's not based on a codesign approach. It's always filtered through the lens of professionals, and I think it's also filtered by the way the research industry is structured in Australia, which requires organisations to meet particular standards, or particular criteria, and that criteria actually excludes the voice of the lived experience. So I think that there's a challenge that the Productivity Commission could put to the research industry, the research sector, about opening up a bit, and that is starting to happen.

But engaging the lived experience more closely in research is important. There are organisations such as CoMHWA, who I believe did a presentation this morning, that are doing very innovative and creative work in that respect, and in particular one project, which may have been mentioned, which is enabling consumers to have conversations with their psychiatrist about the impact of medication. So things that are important to consumers and to families should form the basis of the work that needs to be done in the future.

MS ABRAMSON: Thank you. We made a number of recommendations about the early years, and also schools. I mean I'm understood what you've said to me.

MR CALLEJA: Yes, yes.

MS ABRAMSON: So what are your views about wellbeing leaders in schools and support for schools?

MR CALLEJA: I thought that was a particularly good set of recommendations. I thought the idea of wellbeing leaders in schools shifts the responsibility for the focus of care for children in schools into the classroom, and into the school as a community. At the moment, what happens is I'd have no doubt that there's good work going on, but at the moment it's actually seen not to be a classroom problem or an issue. It's seen to be the work of the social worker, or the counsellor or chaplain or whatever. But by having wellbeing leaders who are there to walk alongside both the children and the teacher, that brings it into the notion of the school as a community.

MS ABRAMSON: I think you mentioned when you were talking about your own background, you have experience in homelessness.

MR CALLEJA: Yes.

MS ABRAMSON: So I'm very interested in any comments, because we've spent a considerable part in one of our sections of the report thinking about the link between mental health and homelessness.

MR CALLEJA: Yes.

MS ABRAMSON: So I'm interested in your views on that.

MR CALLEJA: Again, I was particularly please – I'm sorry if I sounded super negative, but I actually had to hit the foundation stone of the report, but the - - -

MS ABRAMSON: No, I mean we have a difference of opinion.

MR CALLEJA: That's right, yes.

MS ABRAMSON: That's why we have hearings.

MR CALLEJA: Yes.

MS ABRAMSON: To actually hear these things.

MR CALLEJA: I thought that the recommendations around homelessness were really important, and that the recommendation to adopt a housing first approach is particularly important. I noticed that the Commission recommends that the adoption of that is a later strategy. I would think it should be a foundational, immediate strategy, particularly if the Commission is looking at a cross-government. Because there is a growing body of evidence that's indicating a stronger relationship between homelessness and suicide, and that a person's predisposition to suicide will increase fairly significantly when they're homeless.

So you've got a whole push for a suicide prevention plan happening.

MS ABRAMSON: Yes.

MR CALLEJA: Which is now starting to take – pardon me – an across-government perspective. I think the Productivity Commission, if it recommends housing first straight up, would actually help accelerate the suicide prevention plan that'll be discussed in March.

MS ABRAMSON: A number of our – because it's a draft report, we allocated the priorities just as a first blush, but we always anticipated and are looking for comment on our prioritisation, so we'll certainly take that one on board. You did mention, and I'm interested, you talked about – I may pronounce this wrong. The Nottingham, was it LMARC, was it?

MR CALLEJA: Yes, yes. ImROC.

MS ABRAMSON: ImROC.

MR CALLEJA: It's ImROC, yes.

MS ABRAMSON: Yes, so just very briefly, just a little bit about that program, that sounds interesting.

MR CALLEJA: That's a group of agencies. Initially it was established by the UK government health department for a group of agencies, government and nongovernment, to work together to develop a more recovery-based approach to responding to mental health.

MS ABRAMSON: Yes.

MR CALLEJA: They've been operating now for several years and have now formed themselves as a separate legal entity, still with government support. But they have published a series of papers which are available on their website, and which I think that the Commission would greatly benefit by reading, because these are - - -

MS ABRAMSON: I should add, just because the Commissioner's not aware of them, doesn't mean my talented staff aren't aware of them.

MR CALLEJA: Yes, yes, the staff. That's right, yes, yes. But they are very well researched and very well documented, and provide something of a bit of a roadmap that the Commission might want to consider in a way forward. And it's really important, because it is actually adopting a perspective which is de-medicalising rather than entrenching a medical model. It's not saying that you don't need psychiatrists or allied health or whatever, it's not saying that at all. It's just saying actually, you've got to put the person in the middle, and everything has to be relevant and related to that person's recovery.

MS ABRAMSON: I should say, I mean as I said, I've listened to what you've said to us. It would have not been what we would have thought, how our report would be received in the sense that we were very concerned to be consumer focused, but it's very important for us to hear how other people have viewed what we've said. So it was never our previous position to have said medical model is everything, but I've listened to what you've said to me this morning.

MR CALLEJA: Yes, yes.

MS ABRAMSON: So thank you for taking the time to appear.

MR CALLEJA: Please. Okay, thank you.

MS ABRAMSON: And I think Commissioner King has returned. So if I am able – now I may pronounce this wrong, so I'm apologising in advance. Mr Kraan, K-r-a-a-n. I'm sorry, I've pronounced your name wrongly. But you can correct it for the record, and say for whom you appear.

MR KRAAN: So I'm Sjon Kraan.

MS ABRAMSON: Right.

MR KRAAN: Yes, and I'm an individual. I've been a young carer for someone who experiences mental health decline for about nine and a half years, but recently have moved into full time work. So I was a full time carer for nine and half years.

MS ABRAMSON: Yes.

MR KRAAN: So I do apologise, this is not well rehearsed, and I am going to use a smartphone to read the notes.

MS ABRAMSON: No, that's absolutely fine.

MR KRAAN: So don't feel as though I'm being antisocial by not making eye contact. So thank you. So you would have, I imagine, probably had a chance to have a look at the talking points, so I'll do my best to get through this as quickly as possible. So - - -

MS ABRAMSON: So don't feel so constrained. We have a little bit of time.

MR KRAAN: You've got a little bit ahead of time.

MS ABRAMSON: And I'd like you to be able to say what you want to say to us.

MR KRAAN: Thanks so much. So I have read your report, and reflected on that. I was on annual leave, so I had enough time to do that, but - - -

MS ABRAMSON: For which we are grateful.

MR KRAAN: Thank you, thank you, and I'm very grateful for the work you've done. So I identified that reducing service barriers is a very high priority.

MS ABRAMSON: Yes.

MR KRAAN: And I think that GPs should be at the forefront of identifying mental health decline in adults, and I have specifically said adults because I think youth have a lot broader range of opportunities for that to be identified, whether it be school psychologists, headspace and so on. And I think they also have the means and ability to do referrals to psychosocial, psychological, psychiatric and community based residential treatment settings, and I've said here that GPs are uniquely placed in the health system, because they're often the most accessible and commonplace people for regional communities and so on. There's probably less stigma going to a GP, because they're born out of (indistinct) health setting anyway.

And then I've moved onto after hours mental health, and I've said that after hours mental health needs to be given urgent attention and resources, to prevent suicide and respond to mental health crisis more effectively. I think that after hours mental health is not working, and I think that they don't have the resources to meet capacity. I think in proving the ability and awareness of people experiencing mental health crisis, to access an after-hours mental health service outside of emergency departments should be given resourcing priority. And when I talk about after hours mental health, I am more specifically talking about a face to face service, not a help line or online provision, because I think that that's probably covered and improving.

People who are diagnosed with a mental health condition that identify that they are experiencing or becoming unstable, or experiencing deterioration that warrants a relapse prevention type service should be able to easily self-refer themselves to a step up service where possible, to lessen barriers to access. So self-referral, and I think step up, step down treatment services should be expanded wherever possible to reduce hospital admissions, whilst also operating a model which has a less confining experience, and when I talk about that confining experience, it might be a psychological perception of confinement that comes with hospitals, rather than anything else. And also, they operate with a more flexible visitation model and they can give people a better opportunity for transition back to home, whether this be from a hospital – stepping down from a hospital setting, or stepping up to try and prevent hospitalisation.

I think that they focus on personal safeguards, so giving people skills to keep themselves safe, whether this be financial literacy, healthy relationships and so on. And also, they can be a good opportunity for people to connect to services, which they may otherwise not have.

I'd like to talk about funding and the implementation. So upon reflection of the findings of the Commission, I urge the Commission to consider tasking primary health networks with mental health commissioning responsibilities, rather than the creation of new entities, the regional commissioning. I urge this as this will continue to enhance any possibilities of the funding integration, both funding and integrated responses to physical and mental health, rather than fragmenting those two. I also believe that by tasking these already established networks with an expanded mental health task is the fastest way to gaining change, as it provides a foundation to work from and a focus on outcomes, rather than the creation of a new entity.

I do not believe there is a compelling case presented in the report for regional commissioning, and if you have one, I'm happy to be proved wrong. Funding of after-hours mental healthcare by locum GPs or nurses may require a new MBS item, because the current, like locum GP bulk billing, I'm talking about, may not cover that sort of GP visit, and then of course it doesn't cover locum mental health nursing after hours. So that may require a new MBS item.

Funding for non-NDIS psychosocial supports could be enhanced through a GP developed enhanced care plan, which enables full funding affordability, or a choice of provider to the person seeking psychosocial support. So these psychosocial support services that are non-

NDIS have been in a bit of a cloud because of the funding disturbance that has – they've experienced. So when someone wants to, for example, be eligible for Better Access psychology visits, they go to a GP and ask for a mental healthcare plan, and that enables the funding to – and then they can choose the psychologist. And I'm saying that the same model should be considered for psychosocial support, where you know, there's that full funding affordability, they can choose their provider and so on.

It's evident for a long time now that the Australian government has had a key role in funding psychosocial supports, and the full devolution of this responsibility to states does come with risks, a reduction in the services and resources available for psychosocial supports has already been shown to have negative effects. And what I'm saying there is that on reflection from your report, I get a sense that there's some pushback to states to say, 'You guys need to come to service because, you know, federal government has put in a lot to NDIS.' I think that comes with risks because we're already seeing potential reductions and issues with the access to psychosocial supports because of NDIS and it also says to the states, you know, you need to put money up and they might not.

So now, I would like to move on to service delivery. I think the colocation of GP employment and outpatient community mental health services should occur as soon as possible. This colocation would emulate the comprehensive and cohesive model of headspace and enable adult mental health services to better respond to overall health and well-being needs of clients.

So it's more cohesive and I would hope that there would be some form of image change that would also lead to a lower level of stigma, which I think headspace experience and I think that’s probably - well, one of the reasons why headspace has been a target of more and more funding and more and more expansion because people go there because it is less stigmatised, especially young people.

So the next comes probably as common sense; hospitals should be forming discharge plans for patients which seek to prevent suicide risk and promote recovery and these discharge plans need to consider all viable measures for relapse prevention. So because the hospitals' funding is attached to that patient being in hospital. Right? They do have less financial incentive to prevent relapse, so that needs to be considered in those discharge plans.

Care coordination; I mention this because of the strong desire of the Commission, it seems, to create care coordinators or task a role and I think the people should determine - if people are determined to require or benefit from care coordination arrangements they should be given the maximum amount of choice over the provider and structural or funding obstacles to this occurring should be eliminated.

I'd like to talk about carers; parent support and the impact upon children who have parents who experience mental health decline. So carers should be able to access assistance and employment, transitional support or through integrated carer support. Fragmentation of this service delivery should be avoided and I have read in your report that you don't see a veering away from integrated carers support, which I welcome, given a lot of work went into creating that and a lot of consultation with carers and it's probably going to work quite well and I do, once again, see some language in there that you're saying states do need to be funding carers support and I say that if they are going to do that, perhaps, maybe they just fund integrated carers support into that one pool of funding.

So then I'd like to say children of parents who experience long-term mental health conditions should have access to a program which provides education on mental health conditions, so the actual conditions that their parents are experiencing, social inclusion and well-being activities in order to reduce isolation and disadvantage experienced by these young people and to expand on that, there was a program; it was called, 'COPMI'- Children of Parents With Mental Illness - and it was savagely cut for what was described as a savings measure, but it seems a bit savage given there is probably many other places that savings could be made and that was targeted.

So parents who experience a persistent mental health condition should be given access to peer and psychosocial support that enables them to retain their role as a parent or preserve their family functioning. Parents at risk of or demonstrating reduced parental capacity should have resources directed towards a family inclusive support plan to safe-guard the well-being of the family and avoid children leaving the parent's care.

Additional child care subsidy or funds to attain more child care for a time limited period should be considered for these parents when this enables them to pursue actions towards recovery, reduces relapse risk, counters child social isolation and prevents child protection removal. What I'm saying there is that we need to do more investment and more targeted planning to reduce the child protection removal of children from parents who experience a mental illness. That happened to me in my childhood and it could've been prevented.

And the last two points are I watched one of your live hearings and I reflected upon some of the statements made by those participants and I thought about that and I also talked to my mum and asked her whether there was anything that I'd missed and so, first of all, I'll say that my mum and I think that improvements need to be made to the prevention of inpatient sexual abuse.

MS ABRAMSON: Yes.

MR KRAAN: So there are practices that occur in inpatient mental health services where gender segregation doesn’t happen and, you know, we all know that there'd be reasons for that; lack of beds and so on. But, you know, if someone gets raped in hospital this is re-traumatising them, it is going to prevent recovery. So that needs to be taken a lot more seriously and from a legal perspective as well, that duty of care is potentially being lapsed there.

So I would say that genuine safeguards need to be built and more responsibility needs to be made. We've talked a lot about child sexual abuse through the Royal Commission. It would be good not to have to have a Royal Commission about a whole lot of people with mental health decline getting sexually abused in hospital. So I would maybe be able to give you some more clear recommendations on that in a submission.

And then last of all, there was I believe a mental health nurse that made representation to you and there's been some argie bargie about - - -

MS ABRAMSON: We had a number of mental health nurses appear, yes.

MR KRAAN: Yes, and so they do amazing work and especially in the community setting and there's been a bit of argie bargie about how people enter that career and what I can say is that you want the best people. When you look at education quality they keep on talking about teacher quality. How do we improve that? And it's about training but it's also about diversity of people that are coming in. So you don’t want a homogeneous of all of these same people.

So what I have considered about that is I think that some thought should be given to establishing a national career change initiative, similar to Teach for Australia, to promote the role of mental health careers, support career changes into mental health work and maintain a network of paid industry mentors for new mental health work students, both clinical and non-clinical students and advance the quality of mental health work through regular seminars, informal learning that improves both worker resilience and skills and this organisation could be called Mind Work.

So, you know, these people are doing work that requires a great deal of emotional stamina and practices are changing and so and all I'm saying is that both this organisation would both have mentoring roles for mental health workers. I studied mental health and I did an internship out in the field and I think this would've been very helpful for me and obviously I studied it because it - - -

MS ABRAMSON: In the nursing field was it?

MR KRAAN: No, more broadly; both non-clinical and clinical.

MS ABRAMSON: Yes.

MR KRAAN: And it's almost like an industry body, you know, if it's good enough for bankers to have an industry body then, it certainly good enough for these frontline mental health workers to have one as well. So informal learning, training, paid mentorship.

MS ABRAMSON: Yes.

MR KRAAN: So mentorship from the very beginning so that, you know, these people who are putting their livelihood potentially on the line, you know, maybe they're moving - we're talking about career change - maybe they're moving from an accountant to become a mental health worker. Then they’ve actually got some support right in those infancy days of doing that career change.

So that is my suggestion for potentially improving the diversity of people who come into mental health work and also retention from a resilience perspective as well, that you know as a mental health worker that you can go to that industry body or a seminar every three months or something and catch up with other mental health workers and talk about some of the challenges you're facing or some of the victories and achievements that you've had as well. So that’s all I've got to say today. If you've got any questions for me, I welcome those.

MS ABRAMSON: Well, thank you so much because hearing directly from you actually means a lot to the Commission and you've been very eloquent and you've come forward with some really interesting ideas.

MR KRAAN: Thank you.

MS ABRAMSON: I am particularly taken with what you said about the Teach for Australia program and looking at getting people into mental health and you've been incredibly helpful with a number of your suggestions. But I will ask my colleague if he has some questions for you.

PROF KING: Well, before questions, could I encourage you, if you can put a submission in - - -

MS ABRAMSON: To put a submission in.

PROF KING: You mentioned it around the issues of sexual abuse in hospital, but as my colleague has pointed out, I think you have a number - well, I've noted down about three ideas which I'm going to text onto the rest of the team as soon as I get a chance because they're really good ideas. For example, the self-referral and as a step up. It's just sort of what are those things that all - yes, that's something we really need to look at.

MR KRAAN: Yes.

PROF KING: So the questions; first off, just on the PHNs and the fragmentation. So it's sort of a bit on the technical side. We were faced with an issue I guess where there's fragmentation either between the state and federal funding, which we have at the moment for the PHNs and the LHNs. We recognise WA has done a really good job for mental health commission model that it has here by bringing all the state funding together and, in some ways, our RCA model is Western Australia Commission model, but with a federal funds added.

MR KRAAN: Okay.

PROF KING: I guess that's all we're sort of thinking about, but at the same time, we recognise completely that that could cause a split between physical and mental health understanding comorbidities and they need to go together. So, yes, just your thoughts on - you prefer the PHN model - but at the same time, you've probably seen the WA Mental Health Commission model in action so, yes, just a bit more on that. Is there any way we can avoid a split?

MR KRAAN: So I knew this would be a point of further discussion because the Commission seems to be more keen on regional. So there was another component to what I said and that was that I'm concerned that the focus would move potentially, to begin with - because I remember when the mental health commission here was established and it took a long time. So I'm a bit concerned that we need to hit the ground running as quickly as possible on these changes because these are people's lives and I'm a bit worried that the focus would move, to begin with, on creating those organisations; getting the right people in there, cultural and so on, whereas PHNs are already in communities or there and established and they could potentially be a launch pad for these changes.

So that's my concern, and also, if you look at integrated carer's support for example, it's all federal funding. Right? And they've done that because there was a whole lot of different funding and I just wonder whether the federal government will also do what you want them to do and that is to give the states the money to spend as they like as such. So they probably like having that bit of control over how their - especially when it comes to headspace, because then it's an announceable and, you know, they will want to have something like that.

So, yes, I do worry about that fragmentation of physical and mental health and I think that they have quite good synergies - I know that's a terrible buzz word, but forgive me - because I think you've heard from some other people about obesity and we know that housing is another one and I know PHNs aren't going to do housing, but obesity is a really big struggle and also, smoking; so tobacco, and at least with PHNs they can then potentially have some physical health funding that they can put towards that as well.

So I don't have a compelling reason for you not to establish RCAs - I think you're calling them?

PROF KING: Yes.

MR KRAAN: Yes, but I don't think you guys have a compelling reason to establish them.

PROF KING: Could do it rather than the alternative; no, that's a good point.

MR KRAAN: Yes, and I feel as though the Minister would think, 'M'mm, more bureaucracy,' or something like that, whereas, 'Can we just launch off PHNs?' So, look, I don't know what the Minister would think but that's what I'm saying is that if I was in that position, I would be like, 'How can we use what we've got?' and launch from there.

PROF KING: No, they're good points.

MR KRAAN: Yes.

PROF KING: Thank you. One other one for me; you mentioned with the psychosocial supports would be good if consumers have choice of providers - they have more choice. There was care coordination. You also mentioned, you know, care aspect is choice by consumer. The NDIS came up peripherally in your comments. We have sort of been silent at the moment on exactly the way that the consumer and the various supports would interact.

MR KRAAN: Yes.

PROF KING: Whether it would be dollars follow consumer or even a package type of approach as per the NDIS or the more traditional approach which does limit consumer choice and that's something we know we need to do more work in over the next six months or so.

MR KRAAN: Yes.

PROF KING: Really keen to understand your perspective. I guess normally the Productivity Commissions are, yes, the package consumer choice, dollars follow the consumer is sort of what you'd normally expect from us. Somebody said they were amazed they hadn't seen that, but at the same time, we seen the issues with the NDIS and its roll out and we want to make sure we're learning from that experience.

MR KRAAN: Yes.

PROF KING: So I'm really keen - - -

MR KRAAN: So what I would say about that is probably the issues with the NDIS are that it is, you know, there's, like, almost an - my mum calls it an 'invigilation' - sorry, an 'inquisition process'.

PROF KING: Yes.

MR KRAAN: So that’s why I'm talking about GPs as the access point. Same as, you go to your GP, say, 'Look, experiencing mental health decline, need to see a psychologist,' , so exact same access point. There should be a GP in most regional communities or you might be able to do telehealth and then, that’s the access point to psychosocial. So it's a broader enhanced - I think that’s what they're calling them - enhanced health care plans, so then, that’s an access point so then, there's potentially less risk with that.

I guess the other thing is we have to think about the capacity of the person to choose services. Right? And I guess that’s where NDIS has been about in philosophy about empowerment of a person to choose the services which best fit their desires or needs and I would still say, please, preserve that because my mum's experience for example was she has been a recipient of home care services, as they were known, for a very long time and were brilliant for her and that has recently transitioned, if you like, to home support. But that has had a degree of choice for a very long time and that’s a very good thing, especially when a person loses repour or they lose confidence in a service that they can then choose. So block funding is a big issue for that because then, there's a lot more limits on changing and so on.

And I know that in some areas there'll be thin markets and so on and then that's where, perhaps, the innovation fund could work on more capacity for service provision and also, like, the Hireup model where you choose your own worker; you know, that’s a good idea. Especially for psychosocial support in regional areas where, you know, you can't just go round the corner and there's a service provider.

You might be able to go on, or your advocate or your carer, might be able to a digital interface and then, be looking and saying, 'Okay, well, is there someone in our region that would be suited to this person?' and that’s also good from the perspective of - obviously Hireup is about finding people who have similar interest and so on to enrich that person's opportunities to do things with that person that are aligned to their well-being goals and so on.

So I think that I still would urge you to go to full consumer control wherever possible through, perhaps, that access through GP rather than an organisation like NDIS and also, we do have to remember that there's been quite a lot of work done on human services contestability and, you know, that can have benefits for efficiency and so on, and with that in mind, I would say that because a lot of work has been done on that, we should try to, if possible, have some form of contestability because the reality is that some of these block funded services, especially state government, they can get into a rut where they don’t innovate, they don’t respond to changing needs. Right? Because it's the same-old same-old'; we provide this service, we're funded to do it and so on.

Whereas when you put something out in a market, you know, there's a bit of competition. You've got to show the consumer, 'We've got something good for you,' right? So, yes, and also the consumer can also articulate maybe something that they want that’s not on offer, like, Hireup or so on, and I'm not plugging that as a brilliant service or anything. I've not had a personal experience with them, but I'm just talking about models. So, yes, I would urge you to go down that route in the traditional Productivity Commission style, perhaps. Yes.

MS ABRAMSON: I just had one final thing I wanted to ask you about. We've got a number of recommendations around early childhood and support within schools and I'm particularly interested in what you've said to us about being a carer yourself.

MR KRAAN: Yes.

MS ABRAMSON: And our proposal is for a well-being leader in the school that we see as a teacher because we do think it's not necessarily the role of the school to provide psychological support, although they'll have psychologists, because our model envisages that they would connect to external services, but the well-being leader in the school would actually be able to support the classroom teacher.

MR KRAAN: Yes.

MS ABRAMSON: So I'm interested in your views on that.

MR KRAAN: So any recommendations that I haven’t commented on today are because I probably fully agree with them, so I will say that. And I think the well-being leader is a good idea and I think it's a good idea; one, from the perspective of that someone should be leading a healthy culture in schools and also, I think that it does have that onus on that person and the school to say, 'Well, you've got someone who should be looking out for mental health culture in this school,' and also, because in, if you like, almost a former life, I was a youth engagement consultant for the Australian News Forum when Peter Garrett was Minister for School Education and Youth and I was part of a task force on antibullying in schools and our plan was what became SafeSchools.

So, yes, I know that’s quite notorious but we suggested SafeSchools and our actual plan was it was going to be actually attached to Gonski funding. So you may be aware of, like, reconciliation action plans, so we were very inspired as young people by reconciliation action plans and we believed every school should have their own SafeSchool action plan. So then they create it so that it's unique to their - - -

MS ABRAMSON: So it's part of the school community.

MR KRAAN: Yes, but the idea that what ended up happening was Peter Garrett was going to attach that to Gonski funding so that they wouldn't be able to get the Gonski funding unless they had done the SafeSchool action plan.

MS ABRAMSON: You have a lot of experience about how the Commonwealth works on its funding.

MR KRAAN: Well, yes, I take notice of it.

MS ABRAMSON: Yes.

MR KRAAN: Because the thing is, that as you guys have said in your report, there's incentives and the way something's funded incentivises something, whether it either be incentivising apathy because it's just block funded and, you know, you're going to get the funding or there's competition or you're using funding to get a specific outcome and I think social impact bonds are very good for that, if you're after a very specific outcome, and I'd encourage you to look at that, and I think you have looked at that to some degree.

MS ABRAMSON: Yes.

MR KRAAN: And as I say, anting I haven't mentioned today is because I believe it's been covered in the report quite well, and I guess if I've got the chance, I would say that some of the relaxing of the rules around carer payment are good.

MS ABRAMSON: Yes, well, we're very interested in that. One of the difficulties, if I can put it on the table for you with the carer payment, is of course, they're system-wide programs and we were looking at mental health.

MR KRAAN: Yes.

MS ABRAMSON: And one of our concerns was we wouldn't know necessarily the impact on carer payments overall if we made amendments for one particular cohort and concerned us because as an equity issue, why dependent on, you know - - -

MR KRAAN: I think your recommendations are very measured; very, very measured. They're not overly generous in any way that they take into the account the episodic nature of - and I think that's really good, and I think even if it was implemented across the entire carer payment recipient cohort, that would be completely fine. So I don't think that you'd need to section out mental health and then that eliminates any inequities and makes writing the legislation change, because I imagine that might be required, unless it's a regulatory change through DSS, that would make that easier as well, because then you're not, you know, specifically - and from an implementation perspective, it makes it easier for the department as well, because otherwise, they're going to have to try and find out, 'Well, who's a mental health carer,' and you know, 'We're going to have to apply these rules.'

One thing, if I can just mention again, is I did mention improving support for parents who have are at risk of having their children taken into child protection. I understand it's a state issue. I'd hope that you guys would look at that because that's hugely debilitating for parents. You know, they're already experiencing what I would imagine is severe mental health decline and then, they're having their children revoked from them as well, which is very heartbreaking, and I understand that sometimes there's no other choice. But sometimes there really is a choice.

And there is a program called Family By Family. It's The Australian Centre for Social Innovation. They do amazing work. They pioneered this peer-to-peer family model. So the way it works is a family that have traversed immense adversities or maybe have even been subject to child protection intervention. Once they are in a position where their family's function and so on and that they have their capacity, they actually mentor a family who is experiencing adversity or is at risk, and I think that’s great and the other part of that is that there is family preservation pilots going on in New South Wales as well.

And one other thing I would say is that because of the way that a lot of states fund their departments; so a lot of the are moving towards funding a certain amount for a child. Right? And then that funding can only flow to that district office or whatever when a child is under an order and so that’s a really difficult situation when you want to provide a family with, for example, foster care respite. So the young person is not under an order, they are still actually in a custody - - -

MS ABRAMSON: I see what the issue is; but the State can only intervene when they've got the order - - -

PROF KING: An order.

MS ABRAMSON: - - - because that’s what is a trigger for - - -

MR KRAAN: Or they can't pay for the respite; it's a simple as that.

MS ABRAMSON: Yes, no, I understand.

MR KRAAN: Yes, the district offices won't pay for the respite because they don’t have the money because the way the funding is structured.

MS ABRAMSON: Yes.

MR KRAAN: Though I think they've been trying to improve that because that we definitely an experience with my family and that would've been a brilliant prevention measure because my mum, on multiple occasions, did ask, 'Can you do some respite?' and the reason why, because you're probably thinking, 'Well, what about extended family?' because that’s the norm - is, you know, the children would, perhaps, go to grandma, grandparents or something like that - is because my extended family weren’t on the same - they just weren’t prepared to do that sort of thing for my mother and I do come from a single parent family and so there wasn’t a good support network. So we did rely on, if you like, government to provide that and I would say that that is a funding obstacle that should be looked at.

MS ABRAMSON: We'd be quite interested in hearing from you further on that because it backs into the stigma issue of people not asking for help and we've certainly seen that in some of the submissions we've had from Aboriginal and Torres Strait Islander people that they don’t want to ask for assistance because of the issues you've raised.

Can I really thank you? Because that has just been a really quite outstanding submission and I'm sure - welcome a formal submission, and if you could leave your contact details with our staff, that would be terrific.

MR KRAAN: Yes.

PROF KING: It's been brilliant. Thank you very much.

MR KRAAN: Thank you very much.

MS ABRAMSON: Thank you.

MR KRAAN: Bye bye.

MS ABRAMSON: We can take a break now for some coffee.

PROF KING: Yes, An says but reduce it to 10.

MS ABRAMSON: Yes, okay.

PROF KING: So, we'll take a break for morning tea. Now, if we could just have a 10 minute break because we are very pressed for time today so we want to make sure everyone's got as much time to give their evidence as possible, so see you back here at 10.40.

MS ABRAMSON: Thank you. We are on time, though.

PROF KING: I know.

SHORT ADJOURNMENT

RESUMED

PROF KING: Let’s recommence. So Marie Boulianne?

MS BOULIANNE: Yes.

PROF KING: And if you could state for the transcript your name, if you’re representing an organisation, your organisation and any opening comments that you’d like to make.

MS BOULIANNE: Good morning, my name is Marie Boulianne. I’m here to represent myself as counsel for Beyond Words Counselling, but I also work as a clinical nurse for the Department of Health and a lecturer for one of the local universities. However, I am here as of myself today. So basically, my comments in regards to first of all the Medicare items and the role that both a credential mental health nurse and a counsellor could play in terms of being able to have access to those items and to be able to provide accessibility of services to clients prior to severe mental health issues developing so for me in terms of primary health care necessary it would reduce the current waiting period and increase accessibility, reduce distress and potentially prevent decline of mental health, mental state experienced by consumers.

And also credential mental health nurses also have the ability to monitor, you know, the physical aspect but you know, medication initiations and observations or compliance with medications, so work closely with GPs and psychiatrists and other allied services. And be able to also refer back to other specialist services or ED as needed.

In terms of providing low intensity therapy was in regards to Item 5.1 of the report, Low Intensity Therapy Cultures as Alternative to Psychology. Again, I believe the credential mental health nurses and counsellors, registered counsellors, we'd be able to provide such services, and again, be able to provide services to the community as needed.

In terms of 8.2 Child and Adolescent Mental Health Beds, you know, here in the Perth North Metro, there is the youth hospital in the home service, currently as a pilot project here, which is working really well and is helping, sort of have youth avoid hospitalisation or reduce their hospital stay and it can help as a step-up step-down as needed. And such models can be replicated for, I believe other populations such as, you know, for instance, picking pockets of other specialised, you know, sort of, like ADF or DVA population, I think could, we could make comparison and utilise that there.

Also, in terms of more specialist mental health nurses, I know there are some talks in terms of developing an undergraduate nursing - mental health nursing program, which there is value to having, especially trained mental health nurses, but I believe that nurses that would only have that specialty would be at the detriment of patients who have complex care needs which are not exclusive to the mental health aspect and if we are trying to provide a holistic model of care, focussing on just one aspect would be detrimental.

So I do believe that the undergraduate nursing program would benefit from probably just more components in terms of the curriculum or more placements and for universities to have access to more of those placements in hospital base, which they are struggling at the moment. They have to find quite creative ways to find those identical placements, so I think, you know, if there was something that could be done in that aspect to be able to promote the education in that aspect, you know, for mental health nurses – for nurses that would be beneficial. It would also be beneficial for counsellors also who, you know, are, you know, struggling to find clinical placements in the field as well.

Also in terms of 18.1 Training for Educators in the Tertiary Education Institutions. I do support that recommendation and it would add another layer of detection, especially for youths where a lot of the mental health issues or you know, sort of start to develop let's say in high school, a lot of teachers and people at that level will, you know, come face to face with those issues, not always able to know what to do and where to go and how to help their students and so on and so forth. So more training in that aspect. They are not, you know, they will not be classed as counsellors and all of that, however, you know, sort of to help them help those students and to be able to direct them appropriately, would help those students to access care as needed before it escalates. Before we end up seeing them in ED with highly distressed states and so on and so forth. So yes, in a nutshell, that's what I would support.

PROF KING: Okay. Thank you very much, Ms Boulianne. If I can start. So the access to MBS rebates, getting an MBS – a relevant MBS items, getting – begin allowed to access the MBS. We've heard a fairly wide variety of groups saying, 'Well, we need access to the MBS and you know, we've heard from counsellors, we've heard from yourself, you mentioned mental health nurses. We've heard from different forms of therapists who aren't currently able to access those items.

I know what the immediate response from government's going to be. They're going to say well, there's supplier induced demand and if we start opening up the door of the MBS, too widely, the suppliers will come in and the demand will grow to fill it.

How would you respond to that?

MS BOULIANNE: Well, my – because I do work in private practice and I know of the amount of people who are trying to access services, at the moment, they will get the mental health care plan from their GP, trying to find a suitable psychologist who has availability, can take 5, 6 or more weeks. In the meantime, they may not have the financial means to access those services. And even then, by then, a lot of those providers may charge well above the rebate which is not necessarily affordable for them either.

For them, the fact that they are getting something is better than nothing and it's often what they are hoping to get. Private Health Insurance don't rebate, to be honest, not hardly anything in terms of counselling or that sort of a primary kind of health care. And it means that these people wait, so we go from a situational potential crisis that could be resolved quite quickly in probably a few sessions; it will sit there and escalate to a point whereby the time they are able to see a psychologist or one of those allied health with the rebate, it will potentially turn into more of a chronic condition which will take longer to treat and resolve, which by default will cost, you know, the government more money.

I know we're talking about going from 10 to 20 sessions which, you know sometimes people need a little bit more than 10, not necessarily 20. And being able to cater for these people at not necessarily at the top level, but at least be able to give them some sort of financial means to access those services quicker might actually mean they may need less sessions than 20 and then all of – like in the balance, it will probably wash, you know sort of the – everybody will benefit, and reduce wait time, reduce ED attendance, reduce distress calls, so on and so forth.

GPs have to deal with a lot in their 10 or 20 minutes and not always either mentally inclined in that aspect, you know, often they just don't have the time to be able to listen to their patients as much as the patient needs and as much as they would like to as well. The mental health nursing incentive was taken away fairly recently which worked quite well with GPs in terms of being able to have this, you know, really close liaison between, you know, the nursing the patient in that sort of brief, you know, sort of context and be able to refer back to the GP as needed and have this really good synergy between – and providing you know, excellence in care. That's taken away, why, you know, good question? I know it has been raised to, you know, for this to return. And my other question is why credential mental health nurses are not able to access the Medicare item when social workers and OTs you know trained in mental health, similarly to specialist train mental health nurses, why are mental health nurses not? When actually we can provide a well-rounded care to those clients?

PROF KING: Yes, just to pull up on that, they're very good points. Do you know if there's been work done, looking at the rate – because there are waiting periods and the waiting periods differ across Australia for access to say, see a psychologist face to face. Do you know if anyone's done any work actually looking at the rate at which there's a deterioration? So in a sense, I take your point and we should be able to see that in the data. We should actually see there's deterioration because you're forced to wait three, six - or you can't get access at all in many regional areas to the relevant services.

So if you're aware of anything and please take it on notice if you like, it would be good to get some information on that, because then juxtaposing that with a mental health nurse program in the mental health nurse and GP program and being able to see if that then had the reverse effect would be very useful from that perspective. But let me give that on notice rather than asking you to sort of remember academic articles and so on at the moment.

MS ABRAMSON: I'm really interested in the current hospital and the home service with child and adolescent mental health beds, because when we looked at crisis training, you would have seen in our report we saw that there in some crisis where there weren't the means that there should be. So really interested how that works here in Perth?

MS BOULIANNE: Here in Perth, so the model currently has eight beds and the service can cater for youth between sort of 14 to 21 days, so it – like I said, it's a sort of a hospital diversion sort of service so either we are able to contain these youths, you know, at home and as we know, we all recover much better usually at home than in the hospital. It helps reduce sort of institutionalisation for those youth and initiate services and liaise with GPs and other services. So – and we are able to either commencing on medication initiations or monitoring sort of – and cater for a wide variety of presentations from psychosis to eating disorders to anxiety, depression, emerging EUBDs and you name it, sort of, we have a variety of presentations and our team is composed of – it's an allied health team, so psychologist, two social workers, OTs and it's a nursing model and we have a consultant at the head of that. So it's a really good model in terms of being able to you know, care for those consumers from every aspect. In that two weeks and try to – or three weeks – to be able to help them navigate between that crisis point and you know, sort of implement those services. They might have already been known to services, it's just that they need more containment.

However, they don't necessarily need to be in hospital and it's you know, least restrictive practice for them, which is always you know, based on the cognisant mental health - - -

MS ABRAMSON: And I'm assuming it's State funded? And I don't know if you were here in the very first session, but we did have a HBF here interested in what they would be able to do in the community. So presumably, some of the restrictions were lifted on that. Health insurers, they would be able to support things like hospital in the – what – beds in the community.

MS BOULIANNE: Yes.

MS ABRAMSON: Yes. Possibly (indistinct). Yes, thank you.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you.

MS BOULIANNE: Thank you.

PROF KING: Next we have Tricia Owen? Trish Owen? I'm going to grab a bite of scone whilst you're coming down.

MS OWEN: Do I need to give you this? Is that - - -

PROF KING: If you're able to state your name for the transcript, if you are representing any organisation, the name of the organisation and any opening comments that you'd like to make.

MS OWEN: Okay, so my name's Patricia Owen, I am representing my own lived experience. I've got – I've started my own business, I suppose, as a lived experience consultant. So I – yeah, am kind of new into this space. And I read through some of the points in the – did you receive my – I did send some notes.

PROF KING: Yes. I think we've got talking points.

MS ABRAMSON: Yes, we have. We have got them, yes.

MS OWEN: Apologies for the typos. So I wanted to share some of my own lived experience and like, just a brief sort of overview of my story. I'm 39 years old. I was diagnosed with bipolar after three episodes of drug-induced psychosis when I was 20. But my story starts before there. I'm also an Early Childhood Trained Teacher. So I wanted to sort of start from early childhood and stating that I never learned how to feel sad or angry or hurt. Like, I didn't know how to process those emotions. And I, you know, always had that lacking within me. I didn't know where I belonged. I didn't feel like I fitted in with my home or with my – and so – or with people at school. So I worked really, really hard to make sure that people liked me by what I did on the outside.

So I became a bit of an over-achiever, got a Dux award in Year 4 and you know, that made Mum proud and you know Dad even visited for a little while and you know, so there's all those underlying issues and then finding drugs and alcohol from 14, like, my – you know, that filled a gap. Like, that made me feel okay on the inside and I didn't have to work so hard externally to be okay.

And then that kind of stopped working and I had boyfriends. I – a child, I got pregnant at 23, planned to. Found myself in Graylands with my daughter in the Cullity Unit, so you know, with the ups and downs - I still say today I suffer from grave emotional and mental disorders. I don't subscribe to the box of bipolar. I haven't been on medication since 2007. And I have not taken drugs, alcohol, mind-mood altering drugs for the last two years. So when I was in Graylands, I really cried out, like that - you know, that spiritual connection, I cried out to – like

I wasn't brought up religious – cried out to a God. One of the women came in with a little blanket and that was like this little God moment of 'It'll be okay', found myself in a church.

That worked for a while, gave me some sort of purposed admission trips but there was a lot more people to please. So I – you know – so I worked really, really hard there as well. And then when I, you know, I got a degree, like, I found out that I really loved working with children. Like, I really connected with children. I think because they're just so honest and we are too busy wearing our little let's pretend that everything's okay and that we need to be good all the time and we need to be happy all the time. And that's just you know, that's just probably why I believe we have such a mental health crisis, because we're trying to be happy all the time and our emotions are not meant to be happy all the time.

So I got my degree and when I – I had my first year out in a year 6/7 class in Armadale and there were five self-harmers in the classroom. So these are 10, 11, 12, 13 year old children. A lot of DCP children. And I just felt I was the 13th teacher to go into that class to do – because it was joint – that the teacher that was there, could only do two days. And I felt like I just needed to be some constant for those children. But what I also felt as a teacher was that I couldn't tick the boxes that the curriculum wanted me to tick because these kids didn't have the emotional social skills to deal – I was, you know, sort of putting out fires of their emotional and social issues. And really related with that because I, you know, I didn't know it then, but like, I – you know, had my own issues.

And then I left that job and got a role in Early Childhood which when I – and I've written this in some of my points, like, my – I didn't measure up to the Early Learning Framework. One of the – the first outcomes is that children feel safe, secure and supported. And you know, protective behaviours, which I'm trained in as well, tells us that we need to – everyone has a right to feel safe at all times. And it just occurred to me that I didn't feel safe at all times and that, you know, like I was really good at holding space for children to feel safe and secure, but I was going home and drinking myself into oblivion, because I didn't feel safe in my own skin. I didn't feel okay in the world.

And yeah, so I guess that's like – so now I'm starting to see that like, I'm not sure if I'm sick or our system's just sick. Like, you know, the – because we have all these – all these processes and all these structures and they – it's like we have to fit a person into a box to feed them like – for me the mental health system, it was meds and beds. That was – you know, get her in, get her out. Like, I - you know, I had a lot of – a lot of stays in hospital beds and that didn't actually solve my problem. What solved my problem was having a sense of belonging, knowing who I am, where I belong and what I'm meant to do. That sense of purpose and belonging.

And I think that what I've been discovering now is that, you know, we kind of need to go backwards to you know, like, looking at co-design and looking at the Indigenous ways of living, because they have spirit in their – like, in the culture and like, for me, that's when – when I am not feeling okay, and I've just been three days at the conference, so I'm not feeling okay. Like, it's built up a lot of stuff. So this on the back of that is quite intense.

But when I'm not feeling okay, I can go within meditate, pray, find connection with other people who have – who are honest and real with what's going on for them. And that's what – you know, that's what gets me through. Not being subscribed. Not being like put into a box and the people, relationship, like the people that helped me when I was in the Mental Health Ward, I had a community mental health nurse who I could tell he really cared because he had really big bags under his eyes.

That's probably not a good thing; that shows a lack of like, you know, a balance, but you know, educators, mental health nurse, same thing. If they really care, our system burns them out and spits them out because they don't have the ability because of the constraints that are on them, they don't have the ability to actually do what they know that person – like I was in school and like this nurse was for me. And he told me once that 'Oh, Trish, people really get some help sometimes in churches' and I was like, 'What are you talking about?' 'I don't want it. I don't need it.' I actually said the F-bomb, but I won't say that here.

But you know, and – but that, you know, he kind of knew and I suppose now I've experienced that it's those community groups, those not for profits, those groups that are just there because they care and they can, that aren't those groups. That aren't constrained by getting funding and all that that have sort of helped me. Not to put down any other community groups that helps and you know, like WAAMH and CoMHWA and all that. They like, you know, it's all, like, it's all beneficial but where I've got my help has been through those things.

Okay, I need to take a deep breath, because that was - - -

PROF KING: Please. Take your time.

MS ABRAMSON: We've got some water on the table.

PROF KING: I'm going to grab a quick bite of my scone, whilst you're having some water, so.

MS OWEN: Okay. So I guess one of my like biggest points in, I think, where you were talking about the health checks and you know, wellbeing officers.

PROF KING: Yes.

MS OWEN: One of my – like, I suppose, fears that come up with that, is if an educator or a mental health professional doesn't have the reflection skills or the ability to know where they're at, then you know, they could do more harm than good. I don't know what the measures could be in to make sure that someone has progressed in their own awareness. I think this is where lived experience and peer-support is – you know, needs to be valued higher in our professional, you know, in our like, the stigma of that needs to be reduced. But I'm not sure how that's going to happen as well, if people who work in the system are not able to disclose their own lived experience, like, you know, it's quite evidence to me because I'm – you know, I've learned to be hyper-vigilant and when people are a little bit off, I can sort of pick up on it, because I've been there. And when those people who are a little bit off are trying to help you but they're – you can sort of sense that they're not able to help themselves, like, that's not people that I want to put my – you know, I've got a 15 year old – well, she's 16 now. I don't want to – her to be helped by those people and she's wise enough to know that she's not going to be helped by those people, so it's – yeah.

So I think - - -

MS ABRAMSON: Can I ask you a quick question?

MS OWEN: Yes, go, ask me a question.

MS ABRAMSON: And I hope I don't come across as being ignorant about this, but you're a very – a compelling witness, so I just wanted to ask you. When someone has a physical illness, we wouldn't have a view that because they had – you know, they had diabetes, they couldn't work with patients who had diabetes. But you're clearly saying there's something quite different about the mental health space, where a person's own experiences would colour their ability to reach an understanding about a child's situation. Is that what you're saying?

MS OWEN: Yes, that's exactly what I'm saying. For me, when I shared – and it happened a lot in church actually, when I shared with people what was actually going on in my head, I'd get, 'Poor you', and people backing away. Whereas when I share with people who have the same experience and who – you know, who can – and apologies if this offends anyone but this – like, if, um, if I'm like 'oh my gosh, I just want to kill myself today', and that's kind of a not – and I'm sharing that with someone who has those same thoughts and I get, 'Oh yeah', like I know that – you know that, 'Me too', the me too as opposed to poor you.

MS ABRAMSON: Yes, I understand.

MS OWEN: And I think children pick up on that stuff. I remember my first day I was watching a teacher and she would've been nervous, anyone who, like, teaches in a room when you get kind of like watching, you know, everyone here and you know you're being watched, you're a bit nervous and you're a bit, you know, and this little girl a three or four year old said to the teacher, 'Ms So and So, why are you angry?' And she goes, 'I'm not angry, what are you talking about?' And I'm like, 'You've just killed that kids emotional intelligence', she picked up on it and so unless we're able to own it, like, for me I'm like, 'Ms Owen's having a bad day, I need to take some deep breaths and I get them to take deep breaths with me, like, to demonstrate you're sometimes going to feel frustrated and angry and annoyed, here's a skills that you can use.

Which was presented – Di Wilcox presented a book at the conference which is similar to a book that I used to help children understand that, you know, they have some empowerment over their own self. And I think that's what our system does. Our system seems to disempower people and, you know, a psychiatrist knows what's wrong with me, more than I know what's wrong with me. So I've lived with me for 39 years, I don't think, you know, I know me. Like, let me dive into me and find out what the issues are and, yeah, and I think that we don't empower our young people enough to know that stuff.

PROF KING: Our approach with the school wellness leaders was very to say, 'Take somebody who's got teaching experience who understands the classroom dynamics rather than say an outside clinician like a psychologist. So that they can sit in the classroom, they can observe what's going on, because they'll be better experienced to work out, yes, there's something going on that's not quite right here and then they can link – talk to the family and link into the community and so on.

MS OWEN: Yes.

PROF KING: But I think you're adding a really important – I think you're adding a number of really important points. One is that you've got to careful of that wellness leader themselves has issues that they haven't come to terms with, they may actually – that may compromise the role, it may cause damage. Secondly, that peers really should be part of that process. I'm not sure where they'd fit in but they need to be part of that process, am I summarising you right.

MS OWEN: Yeah, I think we need to be careful though, that we're not saying that someone whose unwell because, you know, because recover is up and - - -

PROF KING: Yes. No, no. Yes.

MS OWEN: So it's kind of the self-awareness, like, of that. Um, but – and it's kind of – I suppose the early learning framework is all about a sense of being, belonging, becoming. So that whole sense of belonging, a lot of people that I have worked with and seen in schools and Di Wilcox said this herself, like, if they don't want to be there, like if you're going to choose teachers or – you know, a lot – and I don't know how you measure this apart from an internal just knowing that they are just there to get their pay check. Um, I don't know how you measure this in an external way but we need to – it needs to be the right fit and I don't know how you get that in an external box ticking way which is how our system seems to run as opposed to an internal spiritual knowing kind of way. Like, you know, maybe that's where we need to ask our indigenous elders because they've got that connection to – to – you know, to know that kind of stuff. So, yeah.

PROF KING: But it's a really important point. You know, you don't want to say, 'Well you can become a wellness leader if you're a senior teacher and guess what, you'll get paid an extra amount' and then of course you're just – yeah, you're driving the incentives the wrong way.

MS OWEN: And I think this is where – like, real co-design and co-production in, like, in each setting, needs to happen. Like, I – in the – you know, if I'm a teacher – because a lot of the time a teacher in a childcare centre, decisions are made by the board and we're not actually listening. I mean, you know, I sort of said in here that the co-design needs to happen with the children and the teachers and the parents and the – you know, like, it needs to be that whole – which is hard, messy, unknown, like you're starting with a whole lot of unknown. And what better people to deal with that unknown than people who have been mentally unwell in a system that doesn't know them? You know, like, so there needs to be that all-inclusive, like, in this wellness – yeah, I like the idea. Like, I like it as an idea but I just think the process of how that gets rolled out needs to be done with, you know - - -

PROF KING: Yes, the details matter.

MS OWEN: Yeah, you need to – basically you need to be consulting people like me who are – have got experience in the mental health and have teaching experience and I'm not the only one there's, you know, there's lots of crazy teachers.

MS ABRAMSON: No, it's a really good point because it's something that we'd be saying to the schools that in selecting this person here are some of the criteria that we think that you would be - - -

PROF KING: Yeah almost – you'd almost want peers involved in - - -

MS ABRAMSON: By criteria I mean - - -

PROF KING: Yes, but you'd want peers involved in the selection. I'm thinking that might be - - -

MS ABRAMSON: No, it's a really interesting point - - -

PROF KING: Sorry, I'm thinking off the top of my head now - - -

MS ABRAMSON: - - - which we'll think about.

PROF KING: Okay.

MS ABRAMSON: I wanted to – is that all right?

PROF KING: Please.

MS ABRAMSON: I wanted to ask about housing and education and we had some notes form you so it's only what you feel comfortable in saying to us but I'm really interested in any comments around linking housing services and mental health needs because we do have a strong focus on housing in the draft report.

MS OWEN: Yeah. So, what I suppose, just from my experience, like, I had, um, I think eight or nine visits to mental, um, hospitals. I received housing that was funded by the mental health – like, so it's – I'm in an independent living program, I've been in that property since 2004. Um, so November 2004, my last hospital admission was April 2004, interestingly that since I had secure housing, I haven't had a hospital admission. Like, I have gone in to do outpatient stuff and, you know, my well – like, so – so my recovery, as much as I might say it was when I, you know, started at church or when I started the 12 step program, it actually started when I had a safe, secure place to call home.

I might also add that my – cause I'm also on a tenant action group WA, so it's like a tenants, um, so I hear a lot of experiences of tenants and especially in community housing or, um, public housing. When people are put in – like, where I live I'm in a strata unit and everyone around me owns or private rents their property. Now, that's not to say, you know, like, I don't think our housing continuum is like, you know, public housing is down here and owning your house – because people are people. Um, but for me compared to a friend who was trying to get clean and was living in a whole bunch of strata's where everyone was using, she stayed clean for a while but inevitably she's, you know, back in rehab now.

PROF KING: Yes.

MS OWEN: Like, so when we're, you know, we're needing to understand where an individual – what is best for the individual – they need to have some kind of empowerment over where that property is and what type of, you know, property that is, yeah.

PROF KING: Property it is and the community that they're part of.

MS OWEN: And I think this, like, you know, pathologising that we seem to do with mental health, we don't take into the whole, the social, emotional and so it is good that, you know, housing is – cause that – that is mentioned and that is part but it's not just chucking in a house because if I was – I'm in Fremantle which is where all my - - -

MS ABRAMSON: Services and support.

MS OWEN: Yeah. Whereas before that I was living in Rockingham or sort of between my uncle's in Rockingham and a friend's up in Willagee – and with a one year old, like, so but all my services were up here. So it was, you know, I wasn't secure but if I had have got a place in Joondalup, it wouldn't have worked. Like, you know, so making sure that we matched the person to the place that they are connected with, like, is very important as well.

MS ABRAMSON: No, we've certainly understood that – that connection. And the other issue that we raised in our draft before was we were actually given some evidence that was really quite distressing that people had gone in for involuntary care, lost their tenancy. So those type of issues have certainly been brought to our attention. We don't have easy solutions to some of those things but to say to – we're talking about public housing authorities 'You really need to look at the processes that you have around some of these issue.'

MS OWEN: Yeah, I kind of think it's about all of the systems that are siloed jumping in the room together and having those really uncomfortable conversations because I can't separate my mental health from my housing, from my education, from like, you know, DV or whatever experiences and yet when I need a service I've got to go from here to there, to there, to there.

MS ABRAMSON: Yes, so they're not joined up.

MS OWEN: And then there's too much red – well it seems, from my perspective, too much red tape for those people that actually really care and want to do stuff to help me, they're kind of constrained and their hands are tied because the, you know, because we're in a capitalist society and you can't work there, I don't know if it's just - - -

MS ABRAMSON: But we also have criteria and things that cut people off so you have to look to a certain way, I mean in terms of things about you for a service to become accessible to you. So we sort of have looked at some of those issues.

MS OWEN: And most of the time you've got to be really, really, really, really messed up to get some help. Like, you know, with – I know with my daughter when she was going through a bit of – she wasn't bad enough to get the help, like, you know, she wasn't - - -

PROF KING: You fall into those gaps.

MS OWEN: Yes. So it's like – so you've got where our system is sort of designed that someone's got to be, you know, attempted suicide before - - -

MS ABRAMSON: They've got to be in crisis before the system supports - - -

MS OWEN: Yes.

MS ABRAMSON: Yes, I understand.

PROF KING: Thank you so much.

MS OWEN: Thank you.

MS ABRAMSON: That's been really valuable, thank you.

PROF KING: Next, Mike Anderson.

MS ABRAMSON: I think it goes to the transcript.

MR ANDERSON: Is it all right if I just sit here.

PROF KING: Please and if you could just state your name, if you're representing an organisation, your organisation and any introductory comments you'd like to make.

MR ANDERSON: So, I'm Mike Anderson, local. Not here representing an organisation today although I do, do work with other organisations that do feed into a lot of my experience and what I talk about. I'm mainly here today as somebody that is a person with a lot of experience with mental health and as well as somebody that is studying in employment relations. So part of what I'll talk about is going to be around employment and probably a lot of what I'm going to say is going to be very shaped around an idea of youth involvement in policy making in how we construct our – our health care system, our education systems and everything peripheral to that. Yes.

PROF KING: That's good.

MR ANDERSON: So, just starting on probably what we just came off of, I'll just quickly note with the idea of the well-being leader in secondary settings, there was just a concern from myself and some others that – and interestingly not long after we discussed this an article came out in the media about teachers feeling overwhelmed in students sharing their experience with them.
And I know when I was in high school the people the I first talked to about my mental health, were my teachers and I know that they're already under a lot of stress, a lot of pressure, it's not an easy job being a teacher. While they were very supportive, I understand that they weren't always the most – weren't always the best equipped to be able to, like, say like, 'Well that really sucks, here's how you can help yourself' or anything like that.

It also seems to me that it may be (indistinct) this be a role that sits outside of the teaching role. So more actual focus could be placed on it and more understanding of – just that knowledge that you need to be able to support somebody like that. And I think, as probably as was mentioned before, having a peer in that role would be very much appreciated by a lot of the students. Having somebody that they can, sort of, like talk to, relate to and understand.

And as well as that, I think a consideration should be made that it shouldn't just be necessarily one, um, I think it should probably tie a little bit to, sort of, the region it's in, the type of school it is and perhaps even – and probably more importantly the number of students at that school. Um, my friends and I in the mental health sector discuss, like, I went to school with about a thousand students, and another one of my friends went to school with about 200 and then another one with 1600, so quite a disparity between all of our schools. So it might be something to consider that we look at maybe having a different – having it tied to a little more of like, the needs base than it necessarily is one for all. Yes.

Moving on from that, I'll probably jump into employment a bit because it's my – it's my love. So, there was the discussion around – stuff around like, casualisation and support for mental well-being and psychological workplace health and safety. I believe one of the recommendations 19.2, referenced codes of practice and stuff around basically looking to apply a little more prescriptive than it is now. Or at least that was my understanding - - -

MS ABRAMSON: Yes, it's about a mentally healthy workplace.

MR ANDERSON: Yes.

MS ABRAMSON: Yes.

MR ANDERSON: It was more like a prescriptive role than it is now.

MS ABRAMSON: Yes.

MR ANDERSON: Because it's more of a guide now and I know that some employer groups would rather it be more of a guide than like, that's a little more prescriptive. I think it is important that it is prescriptive. It doesn't have to be super tightened, 'You do this, this penalty' or anything like that or anything like that but making sure that it is very much codified and anything that does happen can be reported in a certain way, can be monitored, can be administered because the important thing that it is such a hard thing to tie down that it isn't really set out in a more concrete way, there's a risk that it will continue to be sort of overlooked a bit. As well as that, it's really important that we do look at that as a major contributing factor to somebody's experience of work because work is a protective factor. But a poor experience of work can remove or even act as a negative to what's experienced, sort of, their mental health.

MS ABRAMSON: We were quite struck, to be honest, that we knew when we talked about the schools that classroom teachers were concerned about how they respond, these thing were happening right now and really the feedback we got was, 'We're dealing with it now, we need to have more support to deal with it.'

MR ANDERSON: Yes.

MS ABRAMSON: And we came up with a particular proposal. But the same was true of employers and the reason that we went down the route of saying, well there needs to be more practical guidance or codes was because a number of employers said to us, 'I know I need to be doing something, I've got all these people coming to talk to me about their programs but I don't know what it is that I'm supposed to be doing'. So that's why we settled - rather than legislation or rather than guidance, we settled on a code because we thought, well in a collaborative process with employers and unions and all the parties involved in that then we would be able to give a bit more clarity.

MR ANDERSON: Yes. Yes, I would like to see those – probably one that's – because I think it was mentioned in there if a workplace has one that is higher or above - - -

MS ABRAMSON: Yes.

MR ANDERSON: So essentially you can think of it in terms of like, an award, as an EBA, better off overall type of case. And I think if that's in place and it is still quite set, that's like, 'This is what you should be doing but you can do more and this is how you can do more.' And I think that would be really beneficial. Moving into casualisation and stuff around non-permanent work, insecure work, while there may not necessarily be any direct reports or any numbers around it, it is generally in the employment relations literature around insecure work that that can be a contributing factor in poor outcomes for mental health. And just levels of stress going up.

It may be less reported especially because people are generally working in those types of insecure work, probably around my age, university students, we're generally not looking for full time work at the moment. But we also should be hoping that we can get some security around that because a lot of us are living out of home for the first time. A lot of us are trying to just get some money so we can, you know, afford to do the things we want to do in our social lives as well. But just making sure that, like, when it comes to that that we do have those protections there because we've had a raft of reports recently of underpayment or workplace abuses and when you're in a casual position and it's a criticism I've been seeing and talking about ever since I sort of started my studies of the casual designation is that there is very little protections for somebody in a casual position. The do get their casual loading, which is lovely, I love my casual loading.

But they don't get the protections that are in place with a part-time or a full-time contract because even after 12 months, you can still be let go or you say, 'Oh, I can't work this day, I have a test' or something like that or maybe if you're not a student, 'I need to look after my child, I need to look after my family member, I need to go do this then, I can't work that day', it's not actually flexible. You will likely end up losing future hours. It's a punitive response to that. I think there needs to be more - and this relates directly to mental health, I know it sounds like I'm just talking about work, because having that security in your hours, not just your work, is really important to having something that's not insecure work.

And then we touch on stuff, and this is really prevalent in the mental health sector, and I do note there was a recommendation for contracts to be extended beyond just a year basis.

MS ABRAMSON: Yes, that was because for the NGOs that provide the service.

MR ANDERSON: Yes.

MS ABRAMSON: I have to say, the Productivity Commission says that on a number of occasions in a number of reports.

MR ANDERSON: Yes. I did -

MS ABRAMSON: You cannot run a business on a 12 month contract.

MR ANDERSON: Yes, I will note the lovely line that I read in the - I don't know if it was in the main report but it was definitely in the overview, a number of the recommendations have been made before. Yes, I did very much appreciate that one because there have been recommendations I have seen before as well. But yes, making sure that because this isn't just a mental health sector thing, it is across the workplace, contracts or a year basis, six months. And sure, maybe that's for the first year, sometimes that is only for the first year. Sometimes it's repeated, you're a year contract.

And I am really glad to see that there is a recommendation to extend contracts out beyond a year because that will provide security. Sure, contracts always come to an end but again, employment can always come to an end. But that five year basis gives you much more time and sets you up much better if you do decide at the end of that five years, well - or they decide at the end of that five years that that job is no longer going to continue, it sets you up a lot better to go find future work anyway and you're probably going to get a lot more lead in time to start searching for work as well because probably by that fifth year, they'll probably say, well, we're probably not going to continue this contract later on, so yes.

MS ABRAMSON: I suppose to be clear, we looked at it - I understand your point by the way.

MR ANDERSON: Yes.

MS ABRAMSON: But we looked at it a bit differently because we looked at it from the perspective of the hirer, if you like.

MR ANDERSON: Yes.

MS ABRAMSON: So the NGO. But of course, one of the things that they all said to us is, well, we can't give our staff certainty and they've got to put food on the table. So although we'd addressed it up there, we knew that it would have an effect down here.

MR ANDERSON: Yes. And that's why I just wanted to note it because I know that it wasn't specifically referenced but it is there. I think it is really important that we do look at making sure that at least - obviously we can't mandate or require it too securely, but looking at methods to incentivise setting out contracts more securely or long term, and because it is really important that there is security in work because if you're not getting that security, you don't know when you're contract's going to end, when you're going to be out of work and that itself has an impact on your own mental health and yes.

MS ABRAMSON: One of the interesting things about our report I think in the mentally healthy workplace space was there was a lot of evidence about what makes a mentally unhealthy workplace but we really struggled when we said, well, but what would you do in a proactive way that would make it a good workplace? It was kind of the converse.

MR ANDERSON: Yes.

MS ABRAMSON: So but then I've taken your point today because you really say that quite strongly to us about casualisation and contract security. I understand.

MR ANDERSON: Yes.

PROF KING: I notice in your talking points you also mentioned stigma.

MR ANDERSON: Yes.

PROF KING: So I'd be very keen to hear -

MR ANDERSON: I didn't have a full chance to read the section on that one.

MS ABRAMSON: Doesn't matter, you tell us what your view is.

PROF KING: No, no. That's understood, that's fine, yes.

MR ANDERSON: Yes, yes. So I will just say I've had a very busy week getting - - -

MS ABRAMSON: You haven't read the 1,234 pages?

MR ANDERSON: Getting ready for a handover at my student union. But yes, with stigma, I think it's always something that we talk about, we always do talk about stigma as something that needs to be addressed but I think very rarely do we talk about what that means and stigma exists in a lot of ways, does stigma exist as my own personal sense of stigma where I feel that I can't talk to somebody? Because I could say to you, 'I have anxiety and depression' and you're probably going to say, 'Okay, let's talk about that'. But if I go tell - if like I myself think oh no, he's going to react very negatively to that, I'm not going to talk to you. And so part of stigma isn't just what everyone else thinks, it's what I think. And it's who we interpret our experience in the mental health sector.

So my first experience in the mental health sector was contacting Headspace and I was anxious to all hell and the first response I got was a kind person on the other end of the phone talking to me slowly, letting me take my time with it because I was just not coherent at first, it took me some time to get my rhythm going and able to talk and that itself is something that means that I'm more likely to trust that service in future. I'm more likely to contact them.

And then when I got into the next part of the service, they talked to me, did that stuff, did, you know, triage. Then they called me a day or two later, just to check in on me and let me know how that process was progressing and what I could expect next. I don't know if all services do this or if all Headspaces for that matter do this but being able to get that, they do actually care about my betterment.

PROF KING: Yes.

MR ANDERSON: Will help to reduce an internal stigma. Of course when we talk about a societal stigma, we've got to look at all aspects of society. We've got to look at stigma in our schools, how does the way that we actually construct our education system impact perceptions around mental health. Obviously when we look at like group projects and stuff in universities, it can create some negative perceptions just because I may not be able to actually contribute fully to a group project because I - or I, with my special consideration, which is also mentioned in the report, take the option of doing it individually. Same work, same all that, I just do it individually. So it can create those perceptions of oh, he has it easy.

So then in workplace it can be they're taking a lot of days off or they've taken this time off for stress leave, they're just bludging or something like that. So it's questions of how do we address those types of thoughts. So yes, it's kind of two pronged, it's not just how I perceive myself, how others perceive myself, how we also - three pronged, I guess, how we actually construct our society and how we construct our workplaces, how we construct our education system, how we construct our government that really inform what our outcomes for the perception of mental health is.

MS ABRAMSON: We were very interested in the university space and we had the opportunity to have someone with a lot of experience, a university counsellor, appear before us at our Melbourne hearings because - and we did ask, one of the things that concerned us a lot was that you might have the counselling service being supportive and assisting the student but then the faculty or the university bureaucracy and administration, for which a number of us have had to deal with, did not provide the support that we're talking about. And you were talking about special consideration.

MR ANDERSON: Yes, yes.

MS ABRAMSON: So we're very open to any ideas as to how that system could work better.

MR ANDERSON: Yes, we had a - we had some work done at my university. I sit on my student union as the disabilities officer, so I have a level of talking on that and I also contributed to our health services review, which included a lot of mental health services. And I think one of the things we've noted was a lot of students reported that yes, the faculty wasn't very helpful and there were some suggestions that were maybe obviously mental health training, but I think that's a very minor thing, because you're not going to change opinions just by giving them training per se. But also potentially having somebody that works on that special consideration front from the service.

MS ABRAMSON: Which is what our - the person who gave - - -

MR ANDERSON: So co-placement basically, yes.

MS ABRAMSON: - - - yes, evidence, said to us. And in fact, he gave us an example of a really simple change. They used to give results to students before the weekend where there was no counselling services available.

MR ANDERSON: Yes, that does happen.

MS ABRAMSON: So if they released it on Monday there were counselling services.

MR ANDERSON: Yes, I think what we have is like it's meant to come out on the Monday, but they still end up releasing it on the Friday. Because they say, like, results come out this day and then you're just like, okay, yes, but it's coming out the Friday because they always release it early. But yes, I think another thing when we talk about the tertiary space and especially with counsellors, a lot of people don't know where to go. I don't think the universities put enough investment in advertising their services and that's not just the counselling service. That's also the disability support service.

So I have people constantly coming to me and saying like, 'Hey, I'm really struggling' and I'm just like, 'Okay, do you have an SRA?' Statement of reasonable adjustment, and they're just like, 'What's that?' And so I'm like, 'Okay, let me talk you through UniAccess, which is the support service at UWA. And they end up going and getting help there and it's really beneficial to them but why didn't they know about that when they started? I did because I was the one who disclosed, yes, I have a mental ill health problem and I need support for that and so UniAccess contacted me and that's how I got in. But not all people actually respond that and I don't think my university actually has the option of - they might, I can't remember, it's been a while since I've done my enrolment, that says to disclose that you have a mental health condition. I don't remember if they actually have that still, they have that yet, there has been talk about it, if not.

MS ABRAMSON: Would you feel comfortable if they did have that though in making that disclosure?

MR ANDERSON: Personally, yes, but not all people do. And I think - and one of the recommendations we did give in our health services review was to say you probably should also say the reason why you're asking this, like say that UniAccess is this service, your response here will only be disclosed to them or something like that. So like have it be sort of giving an assurance that this is a service that will be there to support you and you don't have to use them, you can use them. It's just that it'll allow us to contact with you with more information about them.

MS ABRAMSON: We'd be really interested, if you're able to, to see the report that you've just referred to.

MR ANDERSON: Yes, I don't think the - I don't know if the reports are being publicised just yet, the submissions, that is, because I don't know, it's been a while, I've been very busy with other projects at the moment, but I know that once the - I know that they're going to make all submissions public.

PROF KING: That'd be fantastic, yes.

MS ABRAMSON: We'd be very - if you could just be - one of our staff can be in touch -

MR ANDERSON: Yes, no, of course, yes.

MS ABRAMSON: - and let us know because your evidence has been really, really helpful.

MR ANDERSON: Yes. I submitted one on my own for my own department but I also contributed to the larger guild one.

MS ABRAMSON: No, we'd be very interested in that.

MR ANDERSON: Yes.

PROF KING: Thank you very much.

MR ANDERSON: No worries.

MS ABRAMSON: That's been terrific, thank you.

PROF KING: It's been very - thank you.

MR ANDERSON: Now back to university to do another meeting.

PROF KING: So that's changed. So next Colin Pettit. Hi. So if you're able to state your name for the record, your organisation and any opening comments that you'd like to make.

MR PETTIT: Okay. Thanks very much for the invite. I'm Colin Pettit. I'm the Commissioner for Children and Young People in Western Australia and at this stage representing almost 600,000 young people under the age of 18. In terms of opening statement, I would have a few comments around some of the intent of the recommendations of your report.

PROF KING: Please. Yes.

MR PETTIT: But I'm happy to take questions first if you'd rather do that.

PROF KING: No, no, please, please.

MS ABRAMSON: No, we'd rather have a statement, thank you.

MR PETTIT: Okay. So allow me just a moment. This is just some commentary that our team had a look at the original report and the intent of the recommendations and I just want to make a few points that hopefully will help continue to shape those recommendations. In terms of planning, resourcing and monitoring services with support for children, can I first of all congratulate you for acknowledging the need for early intervention. It's something that in most of the research is very limited and particularly for children and young people and the fact that in many cases children and young people are not deemed to have mental health issues and we need to actually change that viewpoint.

We'd also think that in terms of moving into early assessment, it's a very positive step but it's no point having assessment unless we can also dictate then there are strong programs to support that early assessment. So we think the report could actually lead to more of that if that was possible because in all the research that we've done and I've put in a previous submission, in terms of the two inquiries that our office has done into mental health with children and young people, there are a number of gaps in the service provision and they continue to be there and we've just reviewed our second inquiry, Our Children Can't Wait, which was tabled in 2015 at state parliament. Now, we just reviewed the recommendations and unfortunately most of those recommendations have seen very little, if any, movement in terms of outcomes for children.

So we're still seeing that for children under the age of 12 there are still significant gaps. For children in regional and remote locations in Western Australia, it's always a very difficult thing to manage for any government, but Western Australia throws up a whole range of challenges and we believe that that should be something that the report could actually reflect very strongly about how do we address reasonably country locations because that does seem to be missing.

Obviously around Aboriginal children and young people in particular, groups of Aboriginal children and young people particularly in around need for mental health and suicide prevention, we think that needs to be strengthened and it's still a gap within Western Australia. So even though there has been attempts to address some of these issues in some locations, it still needs a much stronger view - stronger approach, in our view.

The state, to its credit, has actually tried to put a plan in place but the plan is yet to take real effect and so we think your report could actually help stimulate that to a point where it needs to be into the future, if that was at all possible.

In terms of the planning tool, you mentioned the national health service planning framework, obviously it's in for review at the moment, it probably needs a stronger review in particularly in relation to children and young people and they need to be front and centre for everything that happens to them. And we'd like to see that strengthened in your actual approach, if that was possible.

I'll just move on to the role schools play. You mentioned schools a lot and I think they are a really central piece in terms of the solution here. We have come out very strongly in our reports to suggest that there should be whole school approaches to the mental health and wellbeing of all children and we've tried to work with each of the government agencies, each of the agencies responsible for education. They are doing as well as they can within the limited resources, however it needs, in our view, a much stronger attention.

Now, we noted that as part of your draft recommendations, it was around using almost existing resources. Where that's occurred in other environments for education, we find that the resources just move from one point to another and then after a period of time they dissipate. So I think that needs to be strengthened in terms of having deliberate funding placed in schools, particularly smaller schools won't be able to achieve - we have a lot of many small schools in Western Australia with less than 100 children in them and they will not have the resource to redirect into a health and wellbeing strategy. If that approach is accepted as redirection, then we'll find many of those locations won't receive the service and support they need in that place.

So while I agree with you, it needs to have a dedicated person in every school, systems, whether it be Catholic, independent or government, need to have a look at how they would implement that. But I do think it needs to have some serious resourcing behind it and a real dedicated view of what strategy we're trying to achieve in having a wellbeing framework in each of those schools and how will it address the mental health and wellbeing into the future because there is a role here for obviously school psychs but when you talk to the school psych service, they always claim they don't have enough FTE on the ground and it would suggest that schools, from the schools point of view, would also need more. So this needs to be a dedicated service if we can put that in place.

The other area that I think we could actually highlight is that every state, and this state is no different, developed child and family centres under the previous federal government and has now - and each state government maintained those. We have 21 of those facilities in Western Australia. They're all located in low SES locations and the intent was to have a wraparound service for that community through those services.

We have seen varying successes and not so successful opportunities in those centres. We think they could be strengthened to have a mental health approach in each one of those centres, designed for that community, not necessarily the school. We also have called on the state government to expand that program and hopefully roll out more centres. That was one of our recommendations in our last report.

So we think there's an opportunity both to maximise what we already have but also build on that to ensure that those centres are actually spread across our community more broadly. And as I say, 21 for a big state like here is a start but it needs to be continued and it needs to be obviously planned and rolled out in a fairly consistent basis. So we'd be keen for that to happen.

In terms of - I'll move on now to investment beyond health and again I think you're correct in saying that this is not just a health problem and in fact the recent report, I'm not sure whether you've seen, from CoLab, which attempted to have a look at how much money has been spent in crises on children and young people. I don't know if you've seen that report.

MS ABRAMSON: No.

MR PETTIT: I'm happy to table that. Identified that across Australia and across governments there is $1.28 billion being spent on crises for children and mental health, but it's all being delivered through health. None of it's being delivered through any other organisation and children don't just reside in health. And we need to have a look at how do we expand that investment and make that investment real in each of the organisations to address the problems. I'm happy to table that for you.

PROF KING: Please, yes.

MR PETTIT: That is of a draft document, it is released but that's the only copy that I had. So in terms of - - -

PROF KING: Do you need this back, by the way, or?

MR PETTIT: No, no, I'll grab another copy. In terms of investment beyond health, we also called in a report we called Vulnerable Children for the federal government to look at a health and wellbeing strategy for all children and young people in this nation. It's something that we haven't got, it's something New Zealand have started to have and within that should have a look at how do we protect the wellbeing, the mental wellbeing of children and young people into the future. If that was done at a national level it'd allow each state to then use that as a basis to plan and develop many of the strategies that you've already indicated.

So we have called on the federal government to do that and we'll continue to call on the federal government to look at a national wellbeing strategy, like very modern societies around the world are taking on and we think there's an opportunity and maybe your report could actually lead to that, that suggestion if that was possible.

A second bit beyond health that we think could part of your report again is a recommendation we made last year, was that we believe that in every program or investment that is made for children within this state, but you could translate that for national, that there should be a child impact statement put in place. Now, whether that's state, federal or independent funding, we should be looking at what is the purpose of this funding and how is it going to actually make a difference and how will it directly make a difference to children and young people. And if we had an impact statement like that, as we do for the environmental impact statement, it would and should help direct us in a much stronger way into a dealing with many of the issues that young people have and raise with us.

The last - the next issue I'd like to talk about is data and I'm really pleased that you picked up with data. We are in a process of collecting state-wide data and comparing it to national data on a range of issues and we're finding is that the data in the most part is not as strong as it should be and therefore to get real evidence based decisions, the data needs to be improved. And so I congratulate you in actually looking at how do we start to target real data that will make a difference and I'd like to support that within the next part of your report and actually strengthen in terms of how do we link data, how do we gather the data, how does it shared, how - and I'm only talking about young people now but how do they ensure that they understand what data is collected about them and how that information is shared and who's it shared with. And hopefully that will help also with their health and wellbeing into the future.

So data in particular I think is one of those things that needs to be strongly looked at and I know many agencies across WA are looking at that right now but it's not so much the sharing of data, it's about what data do we collect first of all and what is its purpose and how would it actually help make a difference into the future, rather than collecting data on how much money we've spent.

And the last one is one that you have touched on is that the participation of children and young people, obviously I have a slight bias with my position but the voice of children and young people in all decisions need to be central to everything that happens and so when governments start to roll out information or programs or strategies, then they must have a role for children and young people to have input. And we've seen the value of children and young people having strong input, they have ownership and therefore they start to bring about real change as well as being serviced by a better program.

So they're just a few of the dot points that I'd like to first of all thank you for your recommendations but hopefully that will help shape them a little bit further into the future.

PROF KING: Fantastic. Thank you very much, Mr Pettit. Can I just start off, can I come back to the child impact statement because - you were -

MS ABRAMSON: No, no, you ask.

PROF KING: We both grabbed the same thing because we said, ah, that's an interesting idea.

MS ABRAMSON: Because it's an interesting -

PROF KING: Okay, so my background's actually as a regulatory or competition economist, so I see regulatory impact statements and they started out as a great idea and then very quickly became a tick a box exercise. Any thoughts about if we went and looked at a child impact statement, how do we avoid it just becoming a tick box exercise?

MR PETTIT: Yes. It's a great question and it's something that New Zealand are actually looking at right now because they have had a child impact statement for nearly two years and they have it across all their government agencies and it can be quite burdensome, just as an environmental impact statement can. And so we've got to make sure that in trying to achieve something, we don't actually create another layer of red tape.

So the short answer to your question is there would need to be some sort of oversight into occasionally looking at what these impact statements look like externally from an independent point of view and organisations like mine are well suited for that to happen. Just to give it a little bit more of an assurance that it is actually achieving what you thought it was designed to achieve.

PROF KING: That's meant to be achieved, yes.

MR PETTIT: But certainly without one, what we're finding is most of the time children and young people are not thought of. What's happened in many of our organisations, and it's not a criticism, is we always have an adult approach to a solution and we assume that the adult approach will resolve any child's problem as well and for the most part it does but we find in medical procedures, for example, we don't do the exact same medical procedure on an adult as we do to a child, for a range of reasons. And it's the same thing. So we just need to make sure that we've nuanced all of our decisions enough to pick up the needs of today's children and young people.

PROF KING: Yes. No, and point's well taken of course, it can be checked, but if you don't actually have the child impact statement and you have nothing, well that's even worse.

MR PETTIT: That's right, yes. Well I'm always intrigued that governments say that they need an environmental impact statement, and I don't disagree with that at all and there is a real need for that. But when our population is such that across the nation it's almost a quarter of our population is under the age of 18, they are the one group who can't vote, they're the one group who are silent other than through groups like ours, they need a voice and that voice needs to come through processes.

MS ABRAMSON: I think a child impact statement is really interesting and just thinking out loud, the Commission's very strong on evaluation. So the child impact statement is something that could be part of the evaluation process. So if it's done, at least it would give you the benchmark for some of the evaluation that we're looking for later.

PROF KING: So as an initial statement, yes.

MS ABRAMSON: Yes, that's right. That's right. So it's very interesting. I did want to ask you about the voice of children though and how would - we've heard a lot this morning about voice of consumer and we've sort of asked for some sort of targeted advice, well what child in what circumstance and how would we action it?

MR PETTIT: Yes. It's not an easy thing to do for those who are not in the field and certainly using organisations like ours, you can actually get to children and young people. But most of the organisations such as Health deal with young people on a daily basis. Education have children in their schools every day; that's part of the process.

So there are ways we can actually encourage others to take on a role of consultation, and we've got to be careful that it's not just a survey tick-box, but it's a genuine conversation about asking young people, "What is your life experience? How does it look? What does it feel like? How can we improve it? What's working, what's not working?" All of those things. And it does take energy and it does take a deliberate approach, something that our organisation, and I'm sure colleagues around the nation, would be very happy to help any organisation to achieve.

MS ABRAMSON: Thank you. We had some very eloquent evidence this morning about child carers, so I'm interested in some views that you might have about what we can do to support young people who are in caring roles.

MR PETTIT: Yes, it's a really difficult area, and we do need to support both the child and the carers in both of those places. But it is about being clear about processes upfront with carers and what you need from them, and how you need it, and how it's going to be collected and for what purpose. And the same with the young person.

We found, in all of our consultations, if we're really clear with young people about why we need the information, what we will do with it and how we will use it, we have been absolutely blown away with the honesty and brutality of information that young people are prepared to give us, that they often can't give others. And the example I have: we completed a very large consultation in Education just recently, and the information that a range of young people told us, the schools didn't know. And we found that out about them.

MS ABRAMSON: About their personal circumstances?

MR PETTIT: And we found that out really, really quickly, because we were genuine about what we wanted to know from them and why, and what we'd use it for.

MS ABRAMSON: And what were some of the practical things that we could do for young people in those roles?

MR PETTIT: For young carers, yes.

MS ABRAMSON: Young carers.

MR PETTIT: For young carers?

MS ABRAMSON: Mm.

MR PETTIT: I think first of all making sure they've got a voice, and they know where they can actually get information; that's absolutely crucial. And equally, making sure the carers themselves are encouraging them to go looking for issues themselves.

Certainly, in a consultation my office did around concerns raised by children in care, one of the things was that they didn't know who to go to; it wasn't clear to them. Now, that wasn't all of them; some of them were really clear because they'd had great support, so we just need to make sure that, as systems and individuals, we are really clear about how children can make a complaint, how they can find the help they need and who they need to get to. But equally, it's a partnership with the carer, so it's not a random - - -

MS ABRAMSON: I suppose I might've been using carer in a different sentence, but I was thinking about quite young people who are looking after adults with mental health issues.

PROF KING: But they're in the carer role.

MR PETTIT: Yes, they're doing the reverse role, yes.

MS ABRAMSON: Yes.

MR PETTIT: Well, there are a lot of our young people in that space, or growing numbers, so we do need to actually have a way of supporting that. Where we know that's happening - and we don't always do - then where those children cross into other groups or other agencies like education, we need to have processes to find ways to support them; so that's a role for Education to play. It's also a role for Health and for anyone else that's in that space.

MS ABRAMSON: We're very open to any ideas that you might have in that space. The Commission is quite concerned about young carers. We are concerned generally, but they're the least likely, perhaps, to even ask for assistance because they don't see their role as anything different.

PROF KING: And yes, some young carers just think this is life.

MS ABRAMSON: Yes, how life is.

MR PETTIT: And most people in a particular place and time, they just accept that's where they are.

PROF KING: Yes.

MR PETTIT: In terms of your question though, I'm happy to take that and give you some information.

MS ABRAMSON: Absolutely, we welcome it.

MR PETTIT: We can provide that for you.

MS ABRAMSON: We welcome thoughts.

PROF KING: Can I just step back to the schools and the issue - I guess a couple of things there, or two things: one on the funding side for the social and emotional wellbeing strategy. I take your point about the scarcity of funding, but schools - I guess our issue is that schools are meant to already be funded for this.

MR PETTIT: Yes.

PROF KING: I'll give the most extreme example we had where the social and emotional wellbeing classes were formally categorised as recess, which was interesting. So just on the funding side, what's happening with the money that's there? Is it just that the schools are so - - -

MR PETTIT: (indistinct) answer, I won't mind.

PROF KING: No, no, it is a really difficult thing to have, and I think there needs to be a greater understanding of the demands placed on schools; and it's not just in the health and wellbeing space, it's in a range of areas. And we see this daily where the solution for most of our problems we have in society is, schools will address that and so they're being pulled in a range of areas; we see that quite regularly.

Good practitioners, doesn't matter if they're educators or whatever, will make things work, but we're not always - not all of us have the same level of skill, so unfortunately, there are times when you actually have to have a dedicated program to make sure it's spread right across all of the organisation, not just those who can manage it.

MR PETTIT: Yes.

PROF KING: So the short answer around the funding, I think it is scarce and I think the demand is such that it's pulling our systems in every direction. Yes, you're right, schools should have a pastoral care, social, and health and wellbeing view of their students; that's central to having a great school. But when there are so many other demands, sometimes that gets lost.

MR PETTIT: Yes. And so that's why if it's not a dedicated and we're not deliberate in terms of saying from a government perspective, "This is what we expect from the federal government." That's translated into the state government, that's then translated into the school; it probably won't happen.

PROF KING: The other part was I guess on the wellbeing there's leaders and we're very cognisant of the issue that you mentioned that more and more gets pushed back onto the school; so you have psychologists in schools and you've got other counsellors in schools and so on. And I guess our approach was to say, "Well look, that's not what we want from our schools; what we want from our schools is that those who need help can be recognised, that the discussions can occur with the families".

Then, that we have an effective community mental health system so that the family and the child can be guided into the appropriate community level support. So we were saying, you know, you don't need a psychologist in school; what you need is psychologist in community who are then available, and you need the guide in the school, which is really what our wellbeing leader is.

Your comments on that? We recognise that we'll need extra funding by the way, but yes, your comments on that: is that the right way to go? Because some people have said no, you need psychologists in schools.

MR PETTIT: So debate continually rages across all of our systems around psychologists, because when they were first placed into schools to support the schools themselves, they were there for the learning program so their predominant role was to support with the learning difficulties for young children.

Over time, and it's over many, many decades, that has morphed into a whole range of things, including the social and mental wellbeing of children and young people, but the resource itself hasn't changed. We've actually just asked them to look at more things, and that why I said unless you put a dedicated funding into it, it won't happen; we'll end up with it just being watered down to other things.

So the psychologists are absolutely needed, and there needs to be definition around what is their role? Is it around their learning program, is it around their social wellbeing, the mental health, et cetera. And I think it's all of the above, and if that's the case, then they need support to look at how to, once the children identified, who else then gives them support.

PROF KING: Yes.

MR PETTIT: And so I agree with your recommendation around a wellbeing officer, and I think that's a terrific thing. But they would need to be highly trained, they would need to have a capacity, or interpersonal skills, that could deal with not only young people, but also their families, but also make sure that they have the right connections across the community, to support those people. And it may be that we could start those in the child and parent centres.

Rather than say, "Everyone's going to get one tomorrow," let's build it properly and build it well, and then build it up.

PROF KING: Thank you.

MS ABRAMSON: I just had one final comment, which was around stigma. The Commission has a proposal for emotional and social wellbeing checks with young children, in the way that we check for physical checks around hearing and sight. And one of the criticisms we faced is that well, you're actually stigmatising the children from a young age; whereas where we were coming from was actually helping the family to respond to the child's needs.

So I'm really interested in how we might tackle stigma in the context of trying to provide the support and assistance for children.

MR PETTIT: When I've done a number of regional visits in Western Australia and we've talked to young people about seeking medical support and health support, they will often raise the thing about stigma, about there is only one doctor in town, or there's only one door that you can go through, and people know you're going into it. And then the first question is, "What's happening?" And I know that in a couple of our regional locations, they've worked around that by having different doorways into those sort of clinics.

So stigma is definitely one of the things that will limit young people's taking the step forward, and we need to address that. But there are ways around doing that; it doesn't have to have neon signs to say, "We're here to look after mental health;" it could be a range of just, "This is a normal health check," like you would have a school health nurse comes in on a Tuesday and the class is being done. It could be done in school; it could be done in other locations, particularly family centres or whatever, and it wouldn't have that stigma attached.

But stigma is a really important thing to recognise and deal with before we move forward.

MS ABRAMSON: Okay, thank you.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you very much.

MR PETTIT: Thank you.

PROF KING: And they clap.

MS ABRAMSON: Yes, this seems to be a feature in Perth.

PROF KING: They're very friendly people.

MR PETTIT: Thank you.

PROF KING: Thanks. Learne Durrington?

MS DURRINGTON: Good morning.

PROF KING: Good morning. If you'd be able to state your name, your organisation if you're representing an organisation, and any opening comments that you'd like to make.

MS DURRINGTON: Sure, thank you very much. Learne Durrington, and I'm the CEO of the WA Primary Health Alliance. And in terms of opening comments, thank you very much for the opportunity to speak with you today, and to provide some commentary on the report, which is very important to primary health networks, including our own.

Just by way of background, it might be useful for me to just locate us in the broader system. So the WA Primary Health Alliance operates three primary health networks and behaves as a single entity; I say it like that, albeit we operate the three primary health networks. So we are unique in Australia, and we're unique in the degree that for WA, situationally, geographically, this is right for us, and it enables us therefore to have a single voice in terms of working without key stakeholders such as the state Mental Health Commission and the State Department of Health, and others.

So I say that as an enabler to help consider both not only commissioning decisions, but system improvements that we might all agree upon. And at the same time, do very regional work; and I say that, you know, we can move from near Albany to Broome and in and out. So we still do regional commissioning, but we also act in a system way.

I think it's fair to say we've grappled with and have started to get clarity on what are those parts of mental health in primary care that need to be standardised, and what are those things that need to be unique to the context on which the community live? And I think that is the balancing point that's quite important.

The only other comment would be, while we predicate what we commission on whatever is the available evidence, there are settings in WA where there is no evidence that would support what you might do in terms of providing good responses for community. So remote communities, for example, what is the evidence for working with communities where intergenerational trauma is rife, and there are issues of isolation? So I say that. I don't think it's as simple as saying, "Everything's got an evidence base and therefore."

Firstly, we wholeheartedly agree that general practice is the cornerstone of primary care, and from our perspective, it is the gateway into mental health services. That's not to say that the consumer is always well-matched to the service type required, and we also know that general practice often reports feeling - particularly with people with more complex needs - sort of trying to hold it together because of the lack of connectivity between more acute systems and primary care. And that, I don't think is peculiar to WA; I think that is a common response.

The Productivity Commission report also mentioned a service that we commissioned for WA, and partially being our response to having a standardised access for people; so it's the PORT Service, which is a digital mental health service. And so when we came into being, which is four years ago, there were parts of country WA that were not serviced at all by the previous systems; so what was called ATAPS, there was just no servicing. And we felt that there is a need to enable access for populated parts of WA that previously had had none, and part of that solution was PORTS.

PORTS, in that period of time, are starting to provide some very good data that helps us understand the population and what it is that they're seeking; I think that, in and of itself, is an important feature that you know, data as I heard previously - and we all go on about it - but data is key in terms of understanding people's needs and requirements, and what works for them. And we don't always hear that.

The other piece of work that we are undertaking - and again, other PHNs are, but probably differently - the primary health networks are required, rightly, to develop intake and assessment processes that are relatively robust. And we see for us having an intake and assessment process that sits across the WA footprint is going to be really important to link MBS-type services as well as NGO-type services.

Why do I think that's important? It's probably important for a whole range of reasons; firstly, I think PORTS and other services that we commissioned have shown that assessment, in and of itself, can actually be an intervention. We find a lot of people will find the assessment process is actually helpful, not only for their GP, but helpful for themselves in understanding the nature of what's going on for them. So there are quite a few people that would have a brief intervention through a very good and rigorous assessment process. But also, it enables us to have a wider reach around the referral pathways into the system, and that's really the benefit; so it is trying to get the match of the right type of care for whatever it is the individual needs.

I think the other thing we've learnt - and I think this not well-known - but general practice is the primary referrer into what is Better Access, and similarly, what was ATAPS and now for us, PORTS and other services. And I think we're learning that just because a GP has made a referral doesn't mean a person takes it up, and I think that is a key thing for us to understand: what is it about that, what makes the difference for a person to access treatment where they've been referred, and what is the nature of that treatment?

I think some of our data is showing that we are beginning to reach what are probably I think called in the report "under-serviced groups," but people who have a range of needs: so they might have a co-occurring alcohol and other drug issue, or indeed, a chronic disease. But we're learning more about trying to reach that group, who have traditionally not accessed Better Access, or indeed, ATAPS. And I think there is some important work there to be done, going forward, which we can talk about.

So that's the first point: GPs cornerstone. There are lots of great recommendations about building greater capability in and around general practice; I think there are some implementation issues, one being Better Access to psychiatry, we'd all agree. The dilemma we hear from both GPs and psychiatrists is you know, really, ideally, it should be the treating psychiatrist, not just a psychiatrist who can give advice. And so it's a balance there about continuity of care, versus inputs around how to care for the individual. So I just say that. I think there are some good recommendations, but I think there are some fundamental principles to be fleshed-out.

We also concur with you around structural reform in mental health and also the system. And you know, it's pretty interesting - and I say that having been in and around mental health for more than half of my career - we obviously concur that the system needs to be quite well-balanced in terms of the nature of service delivery across the continuum. You would've heard the topic called "The missing middle," from many; it would appear that that notion of secondary care that's community-based is part of that missing middle.

And I would argue that primary mental health as the sort of high-prevalence part of care is not necessarily well-understood once you move inside a hospital. So I'll just say that I think that balancing the system, it's not just about regional commissioning; it's actually about having the right service mix across the continuum, and it's also about ensuring that the - some would call them social determinants - but the converging factors for people, which are about housing, education, meaningful activity - are equally represented.
Because to address a treatment issue without addressing some of the other issues which can be causal in terms of ill-health, means we're just walking in circles.

So while we accept the sort of reform strategy you propose, which is about regional commissioning, we would probably argue that we've started to do that; we don't have all the leaders, and I don't know that anyone does. But to be fair, at least now we can look at the state and we can look at it from both ends of the spectrum: long way to go.

But I think there is an issue around leavers, funding, et cetera. But to have one place where all funding - and it might be the state, it might be the Commonwealth, and it might be philanthropic - but where you can actually see that, would make a huge difference. Particularly in rural and remote areas where we might have funds coming through Prime Minister and Cabinet, you know, PMC coming in, or you know, all sorts of places that are doing great stuff, but totally disconnected. So we would support that notion of trying to find a better way to have visibility and therefore plan where you know, absolutely, what's going on.

There is some discussion in the report around under-serviced groups, and I don't think we can separate out the issues of workforce and local conditions. So for example, in the Pilbara the National Mental Health Service's planning framework would suggest we need 28 clinicians working in the community, and there are two. Now, why are there two? Well, there is a whole range of issues that would underpin the historical sort of development of the mental health service system in the Pilbara.

But you cannot say you need 28 - and you can do it recruiting, incentives for people to stay in more rural communities, whether that's GPs or indeed, psychologists. And many of the providers we commission in the country feel like they have their staff poached, you know, by the state system because they can pay better and they've got different terms and conditions.

So this is quite fundamental, that it's great to improve access but without a workforce, nigh on impossible. And then it's about a workforce who we're clear which type of the workforce do what, and do they have the skills and the capability for the nature of the presenting issues?

PORTS, for us, has been a great enabler because they've provided into some of our rural communities, very good clinical supervision. Now, think of clinical supervision as an enabler to good practice. In some of our regions, access to clinical supervision is virtually non-existent, and therefore, how do you build that capability becomes an issue.

We can talk to some of the work we've done with the state, the Mental Health Commission here, again, about that joint planning and commissioning. And as I say, we've got a long way to go because you've really got to align a number of ducks, more so than just goodwill. And the structures and the policies that sit behind that are quite important.

And why do I say all of that? There is not a jurisdiction in Australia that's exactly the same as the other; they are all different. They've all got different investment levels and on different things. And WA has got its own peculiarities: it's been very hospital bed-based; it still largely is, with a very minimal sort of drive into to the community-based sector, compared to our other jurisdictions.

So if you imagine trying to bring that together, where it's already very unbalanced, it's a long journey to rebalance and get the right mix of services across. And I don't know that just regional commissioning, in and of itself, is the only enabler to that; there are other, perverse incentives in my mind, that you know drive what may happen.

Sorry, I could talk underwater on that, but anyway, I'll stop there. But I think to be fair, it's the implementation of the thought that I think is key. And I look at our colleague PHNs in other jurisdictions, even if it's the ACT, where it's actually one entity, there still are challenges that are driven by state policy objectives and so forth, that actually influence how those things happen. And I don't think we can ignore that.

We really do welcome the recommendation in the report about Better Access. There is significant expenditure that goes out of the Commonwealth to Better Access; it is an enormous contributor to the system, however, it doesn't have the same requirements on outcomes, the same visuals as the rest of the system. I think to rebalance is to really consider where does that type of model fit in a broader continuum?

And the data would suggest that those people who have the sort of assets by which to navigate systems are more often accessing Better Access than those that don't. And so how do we start to repackage Better Access and be clear about its place in the broader system? Because it's grown - as you would probably know - dramatically. And in country areas, you know, there are again perverse things that see a psychology service as a small business, running its business, vis-à-vis, trying to support those who may not be able to afford an out of pocket. So I think there are a range of issues there, so we really welcome the opportunity to reconsider that.

If we look at the outcomes being achieved through PORTS, which is effectively a psychology service but virtual, you can see how you can start to shape-up a range of modalities, rather than it all being face-to-face.

Two more topics and then I'll stop. Rural and remote; I've mentioned the Pilbara and the notion that they should have 28 staff and they've got two. I just think that you know, consideration of how to provide access in rural and remote is an issue, in and of itself. Prevalence would suggest there needs to be far more service than there is available. The notion of stigma, which I heard mentioned earlier, of course is important, particularly in farming communities and so forth. And no one organisation, we believe, in and of themselves, can sort of drive that work.

From our perspective, being an alliance-based organisation, work in partnership with the other peak bodies, the AHCWA, the Aboriginal services and so forth; RFDS is another player in the state system. But really, it takes that degree of collaboration to look at anything that might be sustainable and accessible in some of these rural communities.

I'll just say that the notion of what is an economy of scale is very different in the Pilbara to Albany, and how do you achieve that, what is the right investment and so forth. And while we would say we've got some building blocks; I think that is a long-term strategy that really should have the attention of all of us.

We also build some of our work on the Alliance Against Depression, which came out of Europe, which I think helps reiterate that to impact on the mental health and wellbeing of communities, it doesn't take just treatment; it takes a range of things. And the evidence would suggest that this is about a community creating a health community, a mentally well community. So there is community leadership, community ownership, not only engagement at the general practice, but local government and others. The evidence is quite strong that suicide rates can reduce in those areas where an Alliance Against Depression community-owned, community-driven - and we're doing some of that work in some of our sites. You know, we've got a long way to go but my sense is, the early indications are, it starts to change the sort of trajectory. So it's community-led.

Finally, the thing that I think is really important - again mentioned in the Productivity Commission - but I think the notion of co-occurring health issues and mental health cannot be understated; and from a primary care perspective, that can mean a person with heart disease and depression, or pain and depression. And you know, while we've also tried to bring those topics together, it is really challenging; the health system tends to look at the disease, not the co-occurring mental health. And the evidence would suggest if you do both simultaneously, people go to hospital less, you know, they get better quicker, you know? Again, the evidence is compelling but the clinical workforce and how you merge that, I think is challenging.

Similarly, general practice for us is a beginning point; I'm trying to bring that together. And even though we've got very deep, enduring relationships with lots of general practice, you can see the structural barriers inside the practices. Unless they've got a practice nurse who's got good mental health training and do some screening at the same time, it's very difficult to get that co-occurring depression, anxiety disease linked.

The notion of the system being able to respond better to multi-morbidity, I think is also key. so we would say that the data suggests that people who are multi-morbid tend to be using the system - and I use that really loosely - a lot more, and can be a lot more expensive and a bit played-out by some of the state data here. And again, how do you start to reshape the system to consider that as much as mental health? And I think again, lots of change management is required, and skill development.

We've done quite a bit of work around assisting general practice and specialists to navigate the system; so we use HealthPathways here as one of those enablers, both across the country and in Perth. I have to say, GPs aren't the easiest people to get to change a workflow, but to use HealthPathways enables them to do that, and to find the right service.

So those sort of knitting together the system, we think, is fundamental, because ultimately, our view would be predominantly, for 95 per cent of the population, the GP relationship is going to be the long and enduring care, so how do we enable them to do that effectively and ensure people's care is co-ordinated?

So they're my comments quickly and briefly. And while we really support many of the recommendations, from my perspective, the things that are really important are let's head in the right direction, but how do we implement that, take the system, the sector, the providers, the consumers and carers and families with us? It's a conundrum.

And I think the system, in the last 15 or 20 years, has had lots of things put in it without the coherence across it.

PROF KING: Thank you very much for that today.

MS DURRINGTON: Pleasure.

PROF KING: If I can just start off? You mentioned developing robust intake and assessment processes through the GPs in particular, and the ability then to link up with the MBS and non-government organisation services. Can I have a bit more detail on that? Because as you noted, we're very impressed by PORTS. But you'll notice in our report we say, "This is a great way to go, but the GP is the critical factor."

MS DURRINGTON: Absolutely.

PROF KING: If the GP is going to refer off to face-to-face psychologist-provided therapy, then it's not going to actually achieve what we want it to. So can I have a bit more detail on how you've solved that problem, how have you got that robust intake and assessment process of the GPs sending people in the right directions and to the right services and links?

MS DURRINGTON: I don't think we've solved it.

PROF KING: Okay.

MS DURRINGTON: I think we have sites where the practice, the GP in the practice, is actually working with their patient to enable them to uptake treatment. And of course, the dilemma with MBS fee-for-service type models, the time that that can take for some people is longer than the face-to-face with a GP, and I think that is the dilemma.

So it's clear now where we can see where that work appears to happen; so the person does uptake. Now, they might only have two or three sessions, but they still take up the treatment; where there are others where a referral is made, but the patient then doesn't want to. So we believe there is quite some work, two or threefold: firstly, enabling GPs to have what could be a difficult conversation, what can be a difficult conversation, about accessing treatment and the benefits of doing that, and what then might happen; so forearming the person.

For us, we're starting some work to upskill in practices where we can see that the patient uptake is lower, right? And it's only through PORTS that we can start to see that in a differentiated sort of diffused system like Better Access, you can't actually see that. So the data is important about where are our locations?

The other piece of this from our perspective is, we prioritise more disadvantaged communities than those wealthier suburbs, and we do believe that there is a cohort of people for whom accessing treatment is just too hard, it's too difficult; there are other things that are more important, even though they may be unwell. And therefore, how we enable those people, with peer support and other supports, to actually feel like they can access the treatment.

The other piece of this jigsaw is practice nurses having the training and development; and I think key for GPs, where we have mental health nurses that are reaching into general practice, you can also start to see the change occur, about referring to the right place.

So that's why I don't say we've solved it systemically; we haven't. What we have is a range of I think how information that is enabling us to tailor the sort of supports we put around a general practice; noting that there are 650 of them in WA. Just thought I'd say that.

But we do target those in more high-need communities than those that aren't.

PROF KING: Yes, some of the things you mentioned in there, so peer support, the mental health nurses embedded in the GP practice, which we've heard a lot about; have you started getting the data, are you at the point where you can sort of see more formally that yes, if you've got a GP and there is say, a mental health nurse in the practice, the GP sort of does what GPs do well but then can say, "Right, you now need to see the mental health nurse." It's not, "Go somewhere else."

MS DURRINGTON: No, no, you see them there.

PROF KING: They're down the corridor.

MS DURRINGTON: Yes, that's right.

PROF KING: "Can you wait 10 minutes?" "Yes." Okay, you're in the door, you see them, and that's the person who then links you not just to the clinical but to the community services and does that.

MS DURRINGTON: Yes.

PROF KING: So are you able to see that in the data?

MS DURRINGTON: Early days, early days. And great, great, great, case studies, like, phenomenal. And where those mental health nurses are targeted are practices that are holding or you know, supporting people with more complex needs, because that's where the conundrum comes for a general practice who knows that they need just more than talking to me, they need a few other things, and so they're targeted.

But yes, we could probably fashion-up a report around that. And the PORTS data starts to show where the behaviours of the practice are enablers to uptake.

PROF KING: Yes. So are you using the PORTS data to identify the relevant practices?

MS DURRINGTON: We are, albeit you know, there is confidentiality issues around that. But, yes.

PROF KING: Yes, okay. Because again, from our perspective it's really important to work out, well, where do you start?

MS DURRINGTON: Yes, where do you start?

PROF KING: If we just said, "Roll out mental health nurses in every GP practice around Australia," it's not going to work.

MS DURRINGTON: No, not going to work. It really is a coalition of the willing, and for many practices that are very committed to people with mental health concerns, then that's a bonus; if they're not committed to that, then we don't do it.

PROF KING: Yes.

MS DURRINGTON: So it really is practice-by-practice. And there are some groupings of practices - when I say that, more than one - in certain suburbs, who are really keen to start to have a network of supports that are mental health sitting around their practices as well.

So I think there is some good work to start to emerge with general practice.

MS ABRAMSON: I just wanted to ask about the commissioning of services, because clearly, your PHN model allows you to do that, so we're just quite interested in the type of services such as - what's the word for it - the supported placement for employment, IPS. So we're just kind of interested in how we get that sort of support in a commissioning model, and we thought about that from regional commissioning authority, that they've be able to do it.

MS DURRINGTON: And to be fair, you are right. From my perspective, the limitations on regional commissioning - - -

MS ABRAMSON: Yes.

MS DURRINGTON: - - -if it's only mental health it's going to then diminish the opportunities to enable people to say well, so I agree the connectivity is high. How difficult is it? Very. Why? A million different organisations wanting to do it their own way. My words, right?

MS ABRAMSON: Yes.

MS DURRINGTON: Locally though we've got some great examples of very strong coordination but it really takes the drive and the goodwill.

MS ABRAMSON: Yes.

MS DURRINGTON: Conversely in settings where we've had coordination positions, and it does take a body, like, no-one puts their hand up, to really drive that coordination. The agencies worry about if that person wasn't there what would happen, but they do - they're now really linking together in a way that you can sort of see the obvious linkages rather than all being silos. But that, again, coalition in the willing takes effort, and I think for us going forward as we commission we will be basically describing everything as having to be embedded in an integrated network of services locally. Do not do this alone. Because to be fair most of the things we commission don't do it alone, but I think we've got to get very explicit.

MS ABRAMSON: Yes.

MS DURRINGTON: So we do fund, we do commission some things where we provide the primary mental health.

MS ABRAMSON: Yes.

MS DURRINGTON: And other players do the housing and the other bits and bobs, my words. I don't mean that disrespectfully.

MS ABRAMSON: No, no.

PROF KING: No.

MS DURRINGTON: And they're the people who have been attending hospital a lot.

MS ABRAMSON: Yes.

MS DURRINGTON: And that largely stabilises people. Not only that there are some programs where we commission people who are exiting both - or they're in the court system or indeed exiting emergency departments trying to link them back in to those services. Early days again, but it does - one of the pieces of data is people with bending habits change dramatically. Well, funny about that, because they're getting good supports that are localised and tailored for them as an individual.

PROF KING: Can I follow up on that point? So - I sort of want to say WA is different in a good way, you know, the PHN set up is different to the other states.

MS DURRINGTON: Yes, full stop.

PROF KING: The WA Mental Health Commission is different to other states.

MS DURRINGTON: Yes, full stop.

PROF KING: How is that relationship working? How much depends - so is the relationship between the PHNs, the Primary Health Alliance, and the Mental Health Commission working? How much - if it is, how much does progress depend on it? If it isn't, how much does that create problems? So can I understand that relationship and how - - -

MS DURRINGTON: Yes.

PROF KING: - - -critical or not necessary it is.

MS DURRINGTON: No, it's critical.

PROF KING: Yes.

MS DURRINGTON: It's critical if we want to reduce the traffic going to an emergency department where care can be provided that is less traumatic for a person in the community.

PROF KING: Yes.

MS DURRINGTON: If that's the purpose.

PROF KING: Yes.

MS DURRINGTON: And we would believe that, and we hear GPs say, "The last thing I want to do is send this poor young person to an emergency department", right. So, yes, it's critical also from a continuum perspective. That's the other piece of this. People don't just stay in one service type. They move in and out, up and down, stepped care, getting the right amount of service that they need at wherever they are.

And, yes, so we do quite a lot of work with the Mental Health Commission. We meet monthly. We've got an agenda. We share data. We do all sorts of things. Can we strengthen that? Yes, we can keep going. You know, all of these things in the first instance are about trust, and, you know, trusted relationships working together, having a shared vision, and I think we've come a long way with the Commission. There are a range of dilemmas for the Commission as there are for us, but we agree that if we do this together the benefit is, you know, we won't duplicate, we won't have gaps to the same degree. We can streamline reporting arrangements. There's a whole range of value adds, both providers but also people and consumers. And to be fair the chief psychiatrist is the other person in this, because his remit is wider than - you know, and so it's important for us to also be able to work with him around general practice and what it does and how it does it and so forth, so there are two parts to that.

We also clearly work closely with the hospitals as I mentioned, people being discharged from an emergency department with no service really.

PROF KING: Yes.

MS DURRINGTON: You know, if we want to stop them going back in what do we do. So you can see the benefits no matter where you are across the system. So, yes, I just think it's having - you know, sharing the right (indistinct) as having transparency is critical.

PROF KING: Okay. So you were still working with local hospital districts.

MS DURRINGTON: Absolutely.

PROF KING: But you've also got the Mental Health Commission. Is it then really that the Mental Health Commission just adds another layer of bureaucracy if you've still got to work with LHDs or the LHNs? I can't remember what - - -

MS DURRINGTON: Well, see, this is the topic, that you can't take away the local.

PROF KING: Yes.

MS DURRINGTON: And the Mental Health Commission is not local, it's a state wide, whereas we have local offices and local staff.

PROF KING: Yes.

MS DURRINGTON: So if we're working in Albany with our, let's say a headspace and the adolescent psychiatrist, that's very local about streamlining pathways. Unless the Commission (indistinct) they can't do that.

PROF KING: Yes.

MS DURRINGTON: Right. So you've got to have both, system work and then local to tailor, you know, pick the topic, but I could give you a million examples of that.

PROF KING: Okay.

MS DURRINGTON: So it's really important to have both because otherwise you can't drive it all and hence PHNs exist. You can't drive it from Canberra. It actually takes on the ground. The Commission can do so much but it can't go down to Albany and ticky - around the thing.

PROF KING: Yes, do the hospital - yes.

MS DURRINGTON: Yes.

PROF KING: Yes, okay. All right. Are you likely to put in a submission?

MS DURRINGTON: Yes.

PROF KING: We'd love one.

MS DURRINGTON: Yes, we're doing a WA Primary Health Alliance submission.

PROF KING: That would be brilliant. Yes - no - - -

MS DURRINGTON: I don't know what we're saying but we're going to put in a submission.

PROF KING: Well, following up on some of the issues that we've raised and the ones that you have done would be fantastic particularly rural and regional. We'd love to get a bit more on how to actually get - okay, questions on notice. We've heard already today about issues of access to technology, internet and phones. Really interested to know how PORTS deals with that, so where particularly in rural and regional areas where there are issues of poverty and getting simply access to even just a phone for SMS purposes may be difficult. Also really interested in the rural and regional workforce.

MS DURRINGTON: Yes.

PROF KING: And how do you fill the gaps, because, you know, for example, we've heard that perhaps counsellors should be able to access MBS. My prediction is that if we did that all the counsellors would still be based in Perth.

MS DURRINGTON: That's correct.

PROF KING: And so it actually wouldn't fill the gaps where the gaps really exist.

MS DURRINGTON: Really are, no.

PROF KING: So we're really interested in hearing feedback.

MS DURRINGTON: Yes, okay.

PROF KING: So fantastic. Thank you very much.

MS DURRINGTON: Thank you very much.

MS ABRAMSON: Thank you so much. Thank you.

MS DURRINGTON: Thank you.

PROF KING: Good to stop there otherwise I would've kept going for another 15 minutes at least. Let's take a break for lunch. If we can do it in 30 minutes - 27 minutes and come back at a quarter past, that'd be fantastic.

LUNCHEON ADJOURNMENT

RESUMED

PROF KING: Let me reconvene after lunch. I will just repeat a few of the things that we mention at the start of a day. One is that the microphones are for the transcript. Those of you who are sitting down the back and sort of saying, "It's really hard to hear", our apologies. If you can - you know, if you want to move forward please feel free to do so.

MS ABRAMSON: I have a soft voice.

PROF KING: That's probably the main thing. Yes, okay. I think the rest is all pretty self-evident. Okay, John - - -

MR DALLIMORE: Okay, thank you.

PROF KING: **- - -**would you like to introduce yourself?

MR DALLIMORE: I better do - yes.

PROF KING: And organisation if representing one, and any introductory comments you'd like to make.

MR DALLIMORE: Okay. My name is John Dallimore. I am representing myself as a private practitioner. I've got things written down and then quite happy to deviate from that too. So ever since the Better Access initiative was made available my clients and I have experienced problems associated through lack of access as I'm a non-allied health professional.

I'm a counsellor and a psycho-therapist with a Bachelor Degree in counselling and a second Bachelor Degree in applied psychology. I'm not a psychologist. Post-graduation I have completed nearly 10 years of study and training in psycho-therapy which is a mindfulness based, body centred practice called Hakomi and achieved the level of certified Hakomi therapist. At this stage I'm the only male in Western Australia that's actually got that level of certification. I've also completed a year's training in family therapy. I have attended lots of other forms of development annually just to maintain my level of certification in the Australian Counselling Association. I'm a level 4 member and I'm also a member of the ACA College of Supervisors.

I'm late to counselling. I started my counselling degree on my 50th birthday. Next birthday I'm 70 in a couple of months' time, so it's very much - it was a retraining following retrenchment and going off and doing other things for a while.

MS ABRAMSON: Just for the benefit of the - we will try and get the air-conditioning turned down, so that we can hear you a bit better.

MR DALLIMORE: Yes, okay. Sorry. And there's music coming from somewhere.

PROF KING: Terrific. I will turn - how do we put - okay.

MS ABRAMSON: I'm sorry to interrupt you. We're trying to get you a bit more audibility.

MR DALLIMORE: Yes. Yes, okay.

PROF KING: And having suddenly a hold tone coming through the phone didn't help either.

MS ABRAMSON: Sorry.

PROF KING: My apologies.

MR DALLIMORE: That's fine. It's not a problem. It's a bit like a counselling session. Things just happen. At the time I started my counselling degree I figured it was just something that I could do as long as I was mentally competent into late in life, and it's a - so, along the way I've done I don't know how many thousands of hours of counselling, but many thousands of hours and through that I've - and just through being 70 rather than 40 or 50 I've got so many more life experiences just through age and also through all the different things that my clients have brought to me you can't help but get many, many life experiences from that.

I've worked in government agency settings, been in general counselling, parent adolescent programs, drug and alcohol, juvenile justice in working with kids in detention, I've worked as a fly in/fly out counsellor for Relationships Australia to Port Headland, so the Pilbara, and in that role I developed a - I worked across the whole community and I developed a program that ran for three years with FMG for its indigenous workforce and that continued after I left, but it worked for three years while I was there.

So for 14 years I've been in private practice. Over recent years I've worked with many couples dealing with the issues around FIFO lifestyle having lived it myself, sort of, it's just given me a whole understanding.

I'd like to talk about competition and pricing As a counsellor, who can't access the Better Access program, I've matched my price to the out of pocket level charge generally by clinical psychologists, so the gap. So I charge the gap, because more than that I can - sometimes I'm above it, sometimes I'm below it, but generally I've been around the gap level and currently I'd be at - pretty close to normal gap.

When Better Access came in I already had a full-time workload. I was working 20 - 25 sessions per week over - and one - part of that was one day a week in a medical centre where I was - a GP was referring people to me for generally people experiencing trauma related panic attacks or some sort of somatic related disorders.

My clients had been responding well to the treatment. The Better Access program resulted in the end of that work, so it's put me out of - I just couldn't compete. At the time many non-psychologist allied health workers were providing counselling at or near the Better Access payment level, so if I was charging a gap and there was no gap I just couldn't compete.

Many of my referrals at the time were from GPs. Over a three month period my new client contact reduced to zero as even couple clients were accessing - at the time were accessing rebates under the Better Access initiative. I've since rebuilt my practice based on really established client referrals. The truth is though much of the time after the Better Access initiative was introduced I've been under-utilised in my capacity to work, and I had to reengage in agency work as I rebuilt my private practice like I used to do. I'd work eight days on and six days up to Port Hedland to fly in/fly out and then for three days I also had private clients, so I had a pretty big workload and not one that you could maintain forever.

Now I believe that broadening the access to payments to suitably qualified counsellors would increase competition, maybe reduce prices, possibly not. But it would provide greater availability to well-experienced and competent therapists.

There's one group of clients that I'd like to talk about. I've worked with the Cancer Council referred clients for 14 years. I'm currently their longest serving counsellor on their referral base. I have provided counselling face-to-face, by phone, so if there's people in rural areas, remote, like, yesterday I was into the Pilbara, so - and I've also worked in the palliative care setting for the Cancer Council. I did that for a couple of years. The work is with individuals, couples, family who have some relationship with cancer, either as a patient or a family member. The issues and coping behaviours that present are as many and varied as the people I see.

The approach I tend to take when I'm working is very systemic, so it's sort of just, you know, what's happening here, and over here, and just how this has all come together, which I know you understand from just what I heard earlier this morning.

When I first started working with Cancer Council they didn't limit the number of sessions available. Over the years with budgetary restraints that was restricted to six sessions, and more recently to only four. And two days ago I was advised the Cancer Council will no longer be funding grief counselling and it's suggested that counsellors who are interested can put their name on a register of counsellors to whom they can refer clients so they can access counselling under the Better Access initiative, so again that cuts me out despite years of experience, and I really have lots of experience working with cancer and its effects, I won't be referred the work, and my clients will miss out.

If I can talk a bit more about cancer diagnosis, because one of the things that happens is it very frequently triggers trauma that's not cancer related, it's just trauma related, and all the same sensations and feelings that come up with trauma come up around the cancer and then it triggers the earlier therapy. Old coping strategies, family dynamics become very apparent including very early developmental strategies that may have worked in childhood but no longer worked as an adult.

When complex trauma presents it generally takes more than a limited number of sessions provided by the Cancer Council. I take my duty of care seriously and there are - so, as a matter of course, I've been providing six sessions, two of those are pro bono, because there's now only four.

PROF KING: Yes.

MR DALLIMORE: And I will do more than that if necessary and either - sometimes it's pro bono, sometimes it - I'll negotiate a much reduced price - - -

PROF KING: Yes.

MR DALLIMORE: - - -so someone is paying something and - just it's situational. But what I'm aware of is that as a private practitioner, I can only manage so much of unpaid work, and as far as I'm concerned, it's really the duty of the community to pick up the tab; it's not - I can do some and I will always do some, that's just part of who I am.

One of the things that I'm very aware of is my training was very much emphasised the relational nature of counselling work, and that's always been very important to me. And cancer, by its very nature, brings up issues that are internal in a relationship, and they're external; so it brings up both. And there is no avoiding it, it's just, "This is happening inside me, and I get scared of my own being." And so just helping people manage their anxiety to begin with, and then managing everyone else in the family. But it's work I actually really enjoy doing, so it's fine.

One of the things that often happens is that clients turn up with - they've been to their GP and the GP has written out a mental health plan; l so I get presented with that and then I have to say, "Sorry, I can't accept that. I'm not covered by the scheme." And at that point, clients become distressed unnecessarily, but they do. And there's already been a cost to the community because the GP has been paid to do the plan, and because they've been working with me, generally they'll want to stay doing that work, because you've already got a relationship and it's been working.

So that's one really significant issue that just keeps on coming up; there wouldn't be a week that goes past that I don't get a request or someone says, "I've got a mental health plan." And generally, I'll just say, "Sorry, I can't do the work for you under that plan." You know, my clients have included - and I was just listening this morning - they've included - and it's sort of ongoing there - all allied health professionals so IT, social workers, clinical psychologists, psychologists; it's included GPs and specialist doctors. So I've had the whole gamut. Here, I'm excluded from this system.

If I can talk about GST and the reasons I've chosen not to be registered for GST, and that has a real impact on capacity to earn as well. And I've chosen for a number of reasons to not be registered; one is if I put the GST on top of my fee, I become uncompetitive. So this whole system, the way it's set up now, is quite anti-competitive to someone who has got extensive experience and tertiary qualifications, so I've got both; I just happen to fall through the cracks.

The second reason is - actually, a second reason - is that if I go over a certain level of income, then I suddenly have to charge the GST, so I always have to stay below that.

MS ABRAMSON: I think it's 70,000 or something is the cut-off for GST.

MR DALLIMORE: It's 80-odd now.

PROF KING: Okay, it's gone up.

MR DALLIMORE: But you sort of get close and suddenly, "Oops, I can't work now."

MS ABRAMSON: Yes, I understand.

MR DALLIMORE: Because it has lots of other impacts. And I'm very much a therapist and I'm not an administrator, and having to do - and I do my own paperwork - to have to do that, it's something I've never been good at, not interested in, so I choose not to. If I chose to go into some sort of group setting, again, the GST would be a problem because it would take me over the threshold. You know, you put different people together in a practice and rather than being individuals, I am an individual practitioner, but I really can't do anything other than that if I want to end up with a reasonable sort of income.

Most of my clients have been covered by HBF, and some of them by Medibank Private. For some reason it's really been the other private health insurers. HBF don't cover non-allied health, and Medibank Private covers some under a legacy agreement. I've had one client in the last two years who has managed to claim under that, so again, it really cuts me out of all those opportunities that - - -

PROF KING: Be able to provide the services, yes.

MR DALLIMORE: - - - could lead to referrals. At a personal level, I recently decided to take a part-pension, partly so I could access all the health rebates that are available. And it was that, more than anything. If I could go back to a full working week and be confident that I could maintain that and not have to worry about the GST, I would work full-time.

My father was a dentist; he worked till he was 85. I don't know that I'll work to 85 as hard as he did, but I want to be able to work.

PROF KING: Yes.

MR DALLIMORE: And this is really restricting the amount of work, and it's putting me into the pension system earlier than it should, and it ticks all the wrong boxes.

I wasn't going to talk about personal stuff, other than that, until listening this morning. I have had a lot of interface at a personal level with mental health systems, through my wife has been an in-patient in a mental health hospital. And a few years ago I had trauma, which I'd personally managed to keep at a distance, which relates to abuse and the Royal Commission, the Child Sexual Abuse Royal Commission. During a two-year period, I could only work one or two quiet times a day; that was my maximum, so it had a real impact.

Now, it's sort of just through having done so much work and being quite centred and grounded in my being, I'm back to full capacity, the sort of capacity that I'm used to having. But I have a very real lived experience of interfacing with the health system, and the thing that's been really important for both myself and my wife has been choosing who I saw, right? I really needed a sense of agency.

My wife saw a counsellor who was not covered, and she also saw a clinical psychologist, so she worked with both; I've worked only with someone who falls totally outside, but is a very qualified clinician in the same vein as I am, and who I knew I could trust and would work for me. And that was really, really, important. But it was having a personal sense of agency and choosing how I could get the therapy that I needed, rather than what the system said I needed.

PROF KING: Okay.

MR DALLIMORE: So that's sort of - - -

PROF KING: Thank you very much for that. Actually, I'm going to start the questioning in a slightly different direction from what I was going to. You changed careers at 50, and earlier on we heard something that I thought was very interesting, and isn't something that we'd considered, which is, well, is there a way of bringing more people into mental health careers in general, but as a change of career? So not necessarily saying, you know, the traditional, you finish high school, you go to university, you study in a particular degree.

MR DALLIMORE: I was a property valuer. But do you know what? It's all systemic, so the same stuff but just different: one is people, but they're all interacting systems.

PROF KING: So did you have in your role with your wife and your own lived experience, was that before you made this decision?

MR DALLIMORE: After. I was a counsellor, I did three years with Relationships Australia in Port Hedland; they asked her - she trained as a teacher - and we both lived and worked in an Aboriginal community in the Pilbara for three years, and they asked her to start a program, just engaging with Aboriginal people in the community. That was part of why I got the job, I think, because I knew the people, there was already an in.

PROF KING: So do you find that because you've had lived experience, does that change - well, change is the wrong word. How has that interacted with your role as a counsellor?

MR DALLIMORE: Totally. Like, it's actually - there are very, very many different ways in which I can sort of see - but really, it's a matter of sense for me, very sensed, both sides. And to have some sort of understanding that someone knows I can connect, like, it's either a word or just something like that, but something that just says, - sorry, I put my hand on my chest, which is not going to show up in the script.

PROF KING: No.

MR DALLIMORE: But just something as simple as that, or eye contact, or whatever, but just something that shows someone I get it, and that changes things. One of the people earlier this morning was talking about that, how important that was, and I know that was, and I know that was very important for my wife, and I'm very aware of how important it was for me.

PROF KING: Okay, thank you.

MS ABRAMSON: Thank you so much for sharing your story, because it's hearing those type of things that really informs us. Thank you.

PROF KING: Thank you very much.

MR DALLIMORE: Can I add one more bit?

MS ABRAMSON: Yes.

MR DALLIMORE: What I'm very aware of is amongst the counsellors that I've met and worked with, we've generally done a lot of our own personal work and the things that are there, the traumas that we've met along the way in life, are really why we're doing the work. So we really bring that to our work, in a very positive way.

MS ABRAMSON: I understand, from what you've said.

MR DALLIMORE: And it's about turning something that was negative into something that was positive, and healing others.

PROF KING: Bringing your experiences and your life experience as well.

MS ABRAMSON: And to help other people. I understand.

MR DALLIMORE: Right, thank you very much.

MS ABRAMSON: Thanks.

MR DALLIMORE: Okay.

PROF KING: Thank you. So Taryn Harvey?

MS HARVEY: There's three of us for the association, if that's okay?

PROF KING: Yes, please. And if you could each introduce yourselves and just your organisation and then any opening comments that you'd like to make.

MS ABRAMSON: Thank you for sending through some comments. I know you've just had your conference and we've put a lot of pressure on to do all of these things; so thank you, we really appreciate it.

MS HARVEY: It's my pleasure.

MS HAWKINS: So Kerry Hawkins, President of the Western Australian Association for Mental Health.

MS HARVEY: Taryn Harvey, Chief Executive Officer.

MS McKINNEY: Chelsea McKinney, Advocacy and Sector Development Manager.

MS HARVEY: So after sending you our talking points, actually having sat and listened for most of the hearing this morning, I've decided we can actually come out a little bit.

MS ABRAMSON: Absolutely.

PROF KING: Please.

MS HARVEY: To assist in this perspective. So I guess one of the things - and I think Mr Calleja mentioned this in his address - that we were a little bit surprised at how clinically dominated the report was. And I know, you know, from my experience with the Commission during the NDIS report and from our conversations with you that there was a strong desire to have that lived experience voice reflected in there. But it does appear to be very clinically dominated, and I've even noticed a lot in the questioning today, a lot of focus on psychology for example, around some of the questions.

I guess one of the things for us looking at as we do, particularly in WA - and I think it's important to emphasise that WA is in a different place than some of the other jurisdiction, we do have local commissioning, regional commissioning, effectively; we do have a 10-year plan, a vision for our state's service landscape that was based on evidence, and that was based on extensive consultation and engagement. And it is very widely held by many stakeholders here to be a highly valued vision. We may not have made the progress here that we would like, and that was reflected in the Commissioner for Children and Young People, some of his comments today.

But at the core of that vision is a human rights focus, which I think was missing from the report; my recollection is that it was there in the NDIS report. And that notion of recovery, and a person's lifelong journey living with mental health. And I think using the stepped care framework as the central kind of underpinning I think misses that; I think that brings the focus onto the clinical, the way that that's structured. And particularly around that lifelong journey, you know, puts some of the psychosocial supports at the end of stuff, if clinical treatment hasn't worked.

And I think that really puts us at risk of embedding what is already an unbalanced system. Not only in Western Australia; an unbalanced system is common across the country, and I think there is a risk that the current framing potentially leads us down a pathway of continuing to embed that.

It was good to see some of the recognition of some of the social determinants, and we'll talk about those a little bit more in particular. Having been very involved in the NDIS, I want to make a couple of comments around the balance between access and choice. I would not want to see an NDIS type approach to mental health in this country. I think that the vision behind the NDIS was very bold and very strong, but it has demonstrated to us how ineffectively the federation of who works for, dealing with those people who have the greatest levels of unmet need.

I think we've actually lost an incredible amount in the NDIS, and while I can see that in a desire to bring choice to people, that notion of having money following people is attractive, I think shifting towards a purely individualised funding regime and totally getting rid of block or alternative kind of funding arrangements comes with significant risks. And it really undermines stewardship and commissioning.

So commissioning is not just about buying services; commissioning is about stewardship and it's about holding a vision, a vision of what a good system needs to look like, and thoughtfully creating, with stakeholders, the right services; designing, making sure those services are well designed, well thought out, and purchased properly and given all of the things that they need to make them work. And I think that we do have some room to go in this state as well, but it's just one of the things we wanted to reflect on around getting this balance right between access and choice.

There is a place, I think, for thoughtful stewardship and commissioning, in any system. In terms of prevention I think we've heard some of the conversations around prevention shared today, the importance of family recovery and supporting parents who are living with mental health issues to ensure that the family can stay well and people can stay living with their families, recognising the impact of trauma and the opportunities for trauma treatment and I think the evidence is telling is increasing that trauma is a significant factor across our society in poor physical and mental health outcomes.

I think we've tended to focus a lot on it at the moment in relation to Aboriginal communities particularly but I think it's the more we learn about a whole range of traumas the more it's becoming clear that it's such a significant driver of people's poor outcomes but also that we have many of our service systems and services potentially re-traumatise people and I think that that's one of the things we hear a lot around, you know, clinical services, particularly acute services that are under pressure. We heard some, you know, good discussions around sexual abuse within inpatient services and things like that and again these are the risks on relying on institutional care when we don't have the full range of services available for people.

Social determinants, you know, I notice - well, you may want to talk about it later, the wellbeing stuff, I'd actually like us to talk more about the social determinants of young people's poor mental health and whether our schools are actually designed properly for children, whether they're children friendly places everywhere so that conversation around prevention and really getting to grips with what that means I think prevention is often a term we use without really unpacking some of that stuff and of course the importance of secondary prevention.

I want to talk to you about governance. So the Association, we've just had a clinical governance review here in Western Australia. The Association and our colleagues at Consumers of Mental Health WA strongly support the role of the Mental Health Commission in WA and the bringing together of policy planning and purchasing. I know that, you know, there are different views on how well that's worked. I think that one of the things that we often forget, you know, people talk about structural reform as if somehow structural form magically fixes everything but you could have the exact same issues, you know, if you pool all your funding into one place but I think what the creation of the Mental Health Commission really did was start to shift the conversation and put the voice of people will lived experience and the conversation about recovery much at the fore and I think that that's really important so we would like to see, in terms of rather than creating another layer of commissioning, we would rather see the role of our Mental Health Commission strengthened.

We think there's a lot of opportunity in the relationship with the PHNs here. We'd like to understand a little bit more about how that relationship works and obviously some of the joint planning and stuff is continuing to roll out but we think that the rationale behind the creation of the Commission that those things are still sound and that, you know, there's potentially some opportunity to reinvigorate some of those aspects so that we can progress on the delivery of the ten year plan because we haven't seen the progress towards balancing the system and I think partly some of that stuff is political as well around you can have great planning documents in any service system but there also needs to be political will to change where money is spent and I think that's something that we have probably yet to see some of that political engagement in how the balance system can actually help what happens in hospitals. I think there's a risk that what happens in non-clinical community supports and psychosocial support is seen as something separate, it's not. It's actually really critical to ensuring that our acute and other clinical environments can do their best jobs.

We've had a lot of conversation in Western Australia around patient flow issues in our hospitals with people with mental health issues. A significant report undertaken by our Auditor General here that basically demonstrated that the failure to balance the system is actively contributing to the crisis's that we see in our hospital because, you know, people can't leave hospital be supported in their community because the supports aren't there and we wanted to have a bit more of a look at the numbers in the report around supported accommodation, we're not sure that they're right around the level of supported accommodation here so if people can't leave hospital and stay well in the community that then means that the existing beds aren't able to be available for people who might be in emergency or might be coming and presenting in acute situations which contributes them to our emergency rooms being such fraught environments and as we know, you know, they're probably not the best place for people to be presenting to an acute system anywhere.

So we'd like to really see that the infrastructures that we've created here in WA in a deliberate effort to shift the focus, we'd hate to see those undermined by a national agenda that kind of came in over the top and I think, you know, the fact that we've got a jurisdictional plan I think is a great asset to this State and it's something that we would like to see investment go into because we've spent the time scoping out what that balance system should look like here.

Housing, and I know how important it is in the report too, is a really, really critical issue. Some of the data here suggests that about a quarter if not more of WA inpatients need a home to be discharged to just as in a disability space a lack of housing was always an issue why, you know, certainly in WA pre-NDIS it was a significant reason why funding that had been allocated to people wasn't utilised to the level that was expected because people actually weren't able to leave their family home so the connection between housing and the mental health system from supported accommodation right through to people being supported to transition into private housing and being supported to do that well needs to be examined and we've certainly - you know, the Commission's been working for some time on an accommodation and support strategy that should hopefully give us a blueprint for many of those issues and that the Department of Communities here is also doing significant strategic policy work on planning for some of the other housing issues here so it's absolutely a critical issue.

One of the things that the (indistinct) have been collectively advocating in WA is to put a moratorium on the eviction of people from public housing into homelessness. The data in WA suggests that he number of people being evicted from public housing due to poverty-related reasons is on the increase in the last couple of years. We've asked the government to put a hold on that for families with children and for people with mental health issues because of obviously the risks that that brings to people's health and wellbeing and also housing is a critical issue.

And I guess the importance of a lived experienced voice and building strong systemic advocacy and individual advocacy for people with lived experience having worked as a systemic advocate in disability as well - you know, often when we're designing these things the consumer voice is often the thing that's not valued enough and invested in enough so that it can provide good contribution and to support people to turn their important stories of experience and to turn those into a tool that can contribute to change because that's why people share their stories. So we'd like to see some increased investment in (indistinct) bodies for consumers to support them to be that voice and an increase in advocacy and capacity building. I think I'll leave it there. I think I've touched on probably all of those things.

I wanted to speak about the IPS stuff just thinking about another couple of questions that you asked. We provide an oversight role for IPS across the headspace trial sites and the State Mental Health Commission commissions us to do that as well. You had a question about commissioning kind of non-mental health things in mental health contexts. I think there's actually lots of examples where that already happens. I think that there's no particular reason why so I'm thinking about some of the programs that I'm thinking of in Victoria, for example, where you have housing recovery workers working within mental health services to actually support people to access private rentals, I think there's actually lots of examples where people can either do - you know, look at how agencies can work together to connect services and integrate services but also where, you know, mental health services can also fund things that - or people can fund stuff like, you know, the trial for IPS and headspace sites isn't funded by the Department of Employment so, you know, I think there's no (indistinct words) of the rigidity we have around who does what but really focus on making stuff happen.

And I just want to give one other example where some great stuff is happening around service integration but where I think we need to find better solutions around bringing those funds together and that's around the integration of physical and mental health. I'm thinking of a service here that's based, the Fremantle Wellness Clinic, that presented at our conference over the last couple of days, that's an example of within a mental health service so down in the Fremantle Hospital mental health service, where you've got people with longstanding significant mental health issues and significant physical health challenges, those people are very unlikely to have a relationship with a GP, many GPs aren't equipped to support those people anyway, you've got a service like that that's really actively seeking and contributing its resources to resolve that question. I think there's some ways that we could, you know, help to support some of those services that are seeking that are actively creating opportunities to integrate them and find the funding solutions for them to enable them.

As a systems person I just think we make a lot of assumptions about structure, I think what makes change is people making stuff change and the culture of organisations and leadership and I think we probably need to be mindful of that in how we try to envisage change and how change happens. You know, we can often lay stuff out on a piece of paper but what makes change happen is actually stop people being unable to pick that stuff up and also the culture within organisations as to whether stuff thrives or doesn't.

PROF KING: Okay, thank you very much for that. Can we start off with that last point and feed it back into the Western Australia Mental Health Commission because they were very aware but things happen when you get the right people in the right place with the right supports with the social licence to do stuff so, yes - you know, but you can't built a system, it just depends on individuals so, yes, we see our role in a sense as coming with the foundations that people can then use to create good things in the mental health system.

The WA Mental Health Commission which you mentioned I see as one example of that, as something where you've had the right structure and the right people and we've seen the outcomes and in some ways where we've gone with our approach and thinking about rebuild versus renovate in terms of the structures is that only WA has that structure so even if you have the right people in the other States they don't have the structure to be able to run with and in a sense what we were trying to do with thinking about regional commissioning authorities is to take the WA model, add the federal funding to it and then say, 'We want one of these in every State' so I've said quite publicly that it's the WA Health Commission that is our model for the regional commissioning authorities and I was wondering if you've got any comment about it. Would it be a good thing if say the WA Mental Health Commission got the federal money as well as the state money and was able to then - its policy planning and purchasing was able to all the relevant funding and as we've said in our report we'll need more funding. That existing funding is not going to cut it quite frankly so there's more funding needed as well but that structure.

Well, you also said the WA Mental Health Commission shifted the conversation and I'd really like to explore that further. What was it, and again are we chasing something ephemeral in the sense that, 'Well, it was really the individuals not the structure' and if it the structure, again how do we make sure that the other States can get what you've got?

MS HARVEY: I might defer to Kerry on some of this stuff or to Chelsea but I guess overall I would say, and I don't want to answer for the Commission either so - - -

PROF KING: No, no, no, I understand. I recognise it's an outside view, yes.

MS HARVEY: Yes, yes. And I do get that the vision for the regional commission - I guess the reason I made that point is that my experience with these things is sometimes, you know, governments take hold of a thing and go, 'Okay, and we're going to just forge ahead with this' without ever actually stopping to take account of what's existing and our federation means that national governments tend to like to do the same thing everywhere sometimes and so I guess my reticence was really say look, I don't know what the Commission's thoughts on that were. I think, you know, we would want - what we want is for the vision that's described in the plan to progress and if federal money can make that happen, awesome. I'd rather that federal money didn't come with a whole lot of - - -

PROF KING: Strength.

MS HARVEY: Yes. If that went into the Commission I would like it to be on the condition that I guess, you know, particularly around the rebalancing stuff, the prevention and the community support so if federal funding going into the Commission, I don't even know if that's possible, but yes I don't see why that - yes, that at the end of the day is the important thing for us that the plan progress and that if the feds want to have a greater space in this - because I guess one of the things that we've often heard is the stuff that is in our plan particularly the balance in the system, the message from people like Rosenberg, for example, is that no one wants to own this stuff so actually at the moment it is the responsibility of the States.

PROF KING: Yes.

MS HARVEY: Other jurisdictions decided when the NDIS come to go, 'Oh this is our chance to kind of, you know, retreat'. That was a poor decision and we know that in some of those States they've now had to kind of renege on that and try and fix stuff up so, you know, we're very pleased that our State has held off on that and continues to see at this stage itself playing a role but we've lost moment on that. It's not clear to me that that's just about funding but, you know, if getting a bit of an injection in funds from the feds helped us to get there - you know, if the feds could put money into that plan I'd still rather it came to the Commission rather than the PHNs though because I think that, you know, the role of the Commission - you know, many of those interfaces are back with State service systems as well. I think the Commission's done really - you know, that is a real opportunity there for that from a structural system point of view for a State agency to be able to build those relationships.

I think that's one of the challenges with the NDIS is that you've got a federal agency that's just really struggling to manage the interfaces with the State government agencies so I think that's one advantage. I think the vision and knowing - you know, it was Minister Helen Morton that created the Mental Health Commission and she was also the Minister for Disability and, you know, it's my understanding that the vision for the Commission was very much based on the experience and very much the stewardship-type role that the Disability Services Commission had, its history was that it was created because change was needed so it was a reform oriented - it was recognised that if we wanted to change how the system looked we had to change the culture and one way of doing that was to create a new entity that was tasked with something and the people that - you know, at the end of the day even if you design a system it is about people. You can design, as the Productivity Commission, an ideal system but if the wrong people are running it you still won't get - - -

PROF KING: The outcome.

MS HARVEY: - - - the benefits. So, you know, I think that it was - you know, people who led it were very driven by that desire to strengthen because that's what - and they were driven by also when they worked in disability so I think that culture thing is really important because I think, you know, leading organisations that are about improving people's lives are not just - they're not bureaucratic exercises, right, you have to have a vision, you have to have a culture, and I think one of the shifts, certainly that in the time I've been at WAAMH we've heard from consumers and was one of the reasons why CoMHWA joined with us in articulating to the clinical government's review that we wanted the Commission retained the strengthened is that culturally it's created a different conversation. It's prioritised lived experience voices in a way that it didn't occur within health.

PROF KING: Yes.

MS HARVEY: Kerry, do you add anything to that?

MS HAWKINS: No, no, I think the natural problem though is that you get pushed back.

PROF KING: Okay, you've gone exactly to the point I wanted to go to next which is: to do this you have to get around - to push back you have to get around the vested interests. There are a lot of vested interests, and I won't discuss private conversations I had very early on in this inquiry, but there are vested interests not just here but clearly very, very unhappy with the way the WA Mental Health Commission has gone and the direction that it's moved; how has the change worked to not be undermined and sunk by those vested interests by that push back, I'd be really interested to know? If there's a magic source please tell me in other words.

MS HAWKINS: Look, I think you have to just keep authorising the voice of lived experience and keep putting the rights conversation, the citizenship conversation, the principles at the front of the narrative. We don't think we have the source because we don't think we have the political will to back that up but we have to shift it from being a clinical health conversation to a citizenship and rights based conversation and I think that's critical. I don't think we necessarily have been successful yet but I think we've been one of the strongest States to do that and that's taken years. You know, there's a lot of lag in building up that strong consumer and carer voice but it's been one of the balks against the push back.

MS ABRAMSON: I think to - sorry.

MS McKINNEY: For example, we have a State under consumer peak here in Western Australia funded by the Mental Health Commission. We have the Mental Health Commission leading on providing guidance around exactly how to engage with consumers and families and make commitments around that. We've seen some, you know, early efforts but very recently but, you know, strong efforts, strides forwards, in involving consumers and families in reviewing services and in commissioning arrangements. I mean, these are all things that consumers and carers are telling us are quite radical, for want of a better word, but that is what is needed to raise that voice to a level where the other vested interests that hold that power may be - you know, the Commission is actively rising up those voices as are we and other peaks and individuals and the whole movement and I think that that, you know, rising up of that good old kind like of grass roots power and enabling that authorising that which the Commission is actively doing is one of the things that's needed.

Because, you know, we just had a two conference. We had 450 people come together to talk about mental health and we had a lot of lived experience speaks share their stories about what was helpful and what was unhelpful and all of them mentioned peer support, things outside the medical system. Some of them found some medical treatments helpful as part of their journey but some of them spoke about how they were more unwell after a period of hospital stay or more traumatised than when they went in, all of them emphasises the power of shared humanity and the power of coming together and supporting each other and so we need to be strengthening structures that build and enable that and so that's commissions that are committed to that in their values and in their staffing and in their practise, that's peak bodies for consumers and families, those kinds of grass roots capacity building because not every consumer is able to stand up in front of 450 people and have their say. It's a very courageous thing to do and there's a lot of steps that go before that.

So I think that investment in lived experience capacity building is something that really needs strengthening as well and that's not something that we kind of, you know, that you uniformly see. There's a lot of grass roots activity - you know, good old fashioned kind of community building activity that they're doing that work themselves but in some places there isn't a leader ready and able to step into that space so I think, you know, those kinds of initiatives that build that would be interesting and one of the challenges that we have is that no one is evaluating that work so, you know, could we get some innovation funding tied to a valuation around how that works. You know, can we see our State commissions or the feds investing in what makes that peer support work and those grass roots initiatives and that capacity building, what are the critical ingredients to make that work; everyone's kind of learning a lot from each other but investment in a valuation of that would be amazing and we don't yet see that yet.

MS HARVEY: And the clinical governance review that we've just had as part of that push back is a really good example of having a strong lived experience voice in there that at least gives them pause so we haven't absolutely lost our Commission or been swamped because there was a strong enough person that was part of that process who was supported by a strong network as well to give them that strength to keep at least pushing back, it's critical.

And I think - look, change is hard and this sort of change is a change that changes some of the power dynamics and I think, you know, I gather that people have tried to keep people engaged in that change process and, you know, I think it's easy for people to be threatened by people talking. People tend to feel attacked even when an attack is being made and I also want to recognise that, you know, clinicians are working often - you know, particularly those who are working in acute spaces are working in really trying environments and those workplaces by all accounts aren't always that healthy and I know some of our HSPs are really focused on that but one of the things I hear from people who are kind of grappling with the discomfort of this tension between when we try to bring clinicians and lived experience together - it happened in the conversation we had with Rachel Perkins, people reflecting to me later.

I get that this stuff is hard but I think people who have power also need to recognise that we have to be prepared to give a bit to the people who haven't and not to assume that we're being attacked because, you know, this stuff is really difficult and I think maybe everyone hasn't always been open to staying connected and there have been some barriers to maintaining those relationships in the past but I do also recognise that if you're working in a very high pressured environment it's hard to bring your best self to that - and to that relationship if you're working in an environment that's chronically under pressure, that's facing all kinds of challenges so we do recognise that for clinicians, it's a really challenging environment too and we have to make sure that those environments are as safe for the provision of care as possible and in order to provide good care you need to have a positive environment to do that in.

MS ABRAMSON: We're sort of out of time but I would welcome having a further conversation with you around the rights conversation and citizenship because the Commission did approach this inquiry from thinking out the point of view of the consumer and I've listened very carefully to what you've said about an emphasis on a clinical model so I'd like to understand that a bit more but we'll do that in another forum if that's okay.

MS HARVEY: Yes, yes.

PROF KING: Thank you very much.

MS HARVEY: Thank you.

PROF KING: Jay Anderson.

MS ANDERSON: Yes, I'm here.

PROF KING: Sorry.

MS ANDERSON: That's okay.

PROF KING: If you could state your name for the transcript and any opening comments you'd like to make.

MS ANDERSON: Sure. So my name is Jay Anderson. I'm a clinician in the mental health field and I have dual registration as a counsellor and as a psychologist. I manage a private practice clinic with multidisciplinary team members who provide counselling, psychology services and interventions which also includes Medicare rebated services and EAP services.

Our clients come from a large region south of Perth from Fremantle down the coast to Bunbury including Margaret River and Busselton.

For the last ten years I have been a clinician in mental health and prior to that I worked in child protection for 12 years. So at the moment I've wanted to participate in terms of being involved today and to provide some feedback because of my insights across multiple professions. And in terms of the report there was a number of recommendations and points that have been raised that I was really supportive of and I just wanted to point out some of the gaps and some things that might be beneficial for you.

So under point 1 there was discussion around suicide prevention and aftercare support and I just wanted to highlight the importance not only of case management but also of counselling and therapeutic support wrapped around individuals who have attempted suicide or been within discharge processes. Within our area some years ago we had a program called ATAPS, or Better Outcomes, which had a specific project around suicide support and that program was an excellent model that allowed clinicians to engage with clients across a range of interactions so phone call as well as face to face sessions and for a period of time, I think it was three months, there was unlimited support for those clients and that program was really supportive in terms of helping the clinician and the client to work through those challenges that presented in terms of a client who presented with suicidal ideation. So that model was an excellent program and certainly stood separate to the Medicare system.

Another point I just wanted to raise was in relation to the recommendations in the report regarding psychological therapy and just some comments around the terminology because under Medicare there's a lot of confusion I guess about the mental health items and so when your report talks about psychological therapy it's confusing because psychological therapy as that term is only allowed to be provided under Medicare by clinical psychologists. So as a - - -

PROF KING: Not by registered - sorry, to interrupt.

MS ANDERSON: No, no.

PROF KING: So registered psychologists and clinical psychologists both provide therapy but - - -

MS ANDERSON: No. No, and that's what I want to explain to you because it's very important that people understand the difference.

PROF KING: Okay.

MS ANDERSON: So allied health providers, OTs, social workers and psychologists are only allowed to provide focused psychological strategies, that's not therapy.

PROF KING: Okay.

MS ANDERSON: There's a lot of therapies that counsellors and psychologists are trained in. Medicare restricts us from providing therapy to our clients so under Medicare - - -

PROF KING: Can I just say - - -

MS ANDERSON: Yes.

PROF KING: Again this is clarifying from my perspective.

MS ANDERSON: Yes, sure.

PROF KING: Because I have read the relevant Medicare documents and I'm trying to remember because it's been a while. I thought the limitation was actually to CBT. I'm sure cognitive behavioural therapy is actually mentioned somewhere.

MS ANDERSON: It's listed as 'focused psychological strategies'.

PROF KING: Okay, so that's how it's got - - -

MS ANDERSON: Which includes components of cognitive strategies and behavioural strategies but it's not therapy.

PROF KING: Okay, okay.

MS ANDERSON: So under Medicare psychologists are restricted in their practice and across Australia all psychologists are actually registered with AHPRA as psychologists and privately with any client that we see outside of the Medicare system we can provide psychological therapy but under Medicare we are restricted in our practice.

PROF KING: Yes, I knew the Medicare restricted but - okay, so I agree we've been a bit loose with the words there, so.

MS ANDERSON: It's the terminology which - - -

PROF KING: Because there's a whole range of therapies that you can't offer under Medicare.

MS ANDERSON: Yes, that's correct.

PROF KING: Yes, okay.

MS ANDERSON: And so certainly in terms of psychologists they are not actually able to provide their clients with the therapy that they might need if they're working under the Medicare system so that's one of those difficulties in terms of helping clients in the community with their mental health needs that I wanted to point out.

PROF KING: Yes. Can I ask - sorry, I'll stop interrupting in a second.

MS ANDERSON: That's okay.

PROF KING: There's the Medicare rules and then there's what the psychologists actually do for the clients in terms of the therapy so the rules are very restrictive. It's been suggested to us that many psychologists don't just do the cognitive behavioural therapy type of approach that's built into or is assumed in Medicare but, for example, if they're dealing with trauma patients or consumers with trauma, there's no point doing that, it's the wrong therapy and they will choose a better therapy or the correct approach from a clinical perspective even though it may not be quite kosher.

MS ANDERSON: I guess that's an area that would be good to research and survey our profession on but certainly in terms of what we're required to work under Medicare it is limiting for our profession, yes. There was a point in the report that talked about clinicians at entry points to the health system and several recommendations about GPs being reimbursed for treating people with mental health. I just wanted to point out - and I actually feel that our professional and a lot of people in the community aren't aware that GPs actually already are significantly reimbursed for treating people with mental health. I only discovered this year as part of other research in terms of the profession that GPs are actually allowed to provide focused psychological strategies and what surprised me, and horrified me to the tell the truth, is that GPs are only required to have undertaken 20 hours of training to do that and they get paid far more than a psychologist or a clinical psychologist.

That concerns me because clinical psychologists and psychologists have done extensive training in psychological therapy, a minimum of six years, and I'm sure if the medical profession found that us as professionals were going to do something medically-related they would have a much higher expectation of our capacity. So for one profession to cross over into another professional with only 20 hours of training and get reimbursed for more than those specialists is quite concerning and I think that's part of the issue in terms of the Productivity Commission's investigations around clients' mental health in the community is that as clinicians if clients can go to the doctor for focused psychological strategies and be bulked billed, they are not actually seeing the specialists who are trained to do that.

There was another point made in the report about a greater role for mental health nurses and a passing comment about there not being any need for psychologists because there's lots of them already. I think the issue is not about the number of psychologists but about the role that they play and it's important, again just highlighting my point about as AHPRA registered clinicians psychologists are actually not being utilised for the full range of services that they can provide under Medicare and so therefore as a psychologist I would be advocating the psychologists need to be able to undertake psychological therapy for our clients in the community.

The challenge that we have is that medical model has a strong focus on bulk billing. Lots of clients go to doctors and want to get bulk billed and we heard from our colleagues in the counselling profession about the impacts of that on them as well and certainly that's a challenge when GPs tell their clients about the free counselling under Medicare and lots of people expect a free service and the challenge that we have is that the rebate provided under Medicare doesn't cover the costs of providing that service.

And just one other point I wanted to raise was in relation to EAP services, so employee assistance programs, and that was in the sense that a lot of EAP companies have set a standard which is impractical and not relevant in terms of that EAP services so an EAP service often is three sessions or maybe six so it's short term solution focused counselling and often EAP providers require five years' experience from a counsellor. Most of the time those registrations are only for psychologists so again psychologists who are highly skilled having done their six years training can't actually provide those services until they have five years of experience so again in terms of providing support to companies and clients within companies the standard is set up here when actually psychologists are fully capable to provide that service and counsellors as well I would like to add because there are only a couple of companies that allow counsellors to provide services whereas in reality counsellors and psychologists could provide the solution focused brief counselling that is serviced under EAP.

MS ABRAMSON: I'm really interested in this and encourage you if I could to put in a written submission even about that because it is the Commissioner's intention to look a bit further at EAP schemes and to consider what would a good EAP scheme look like? What are the key components? So what you've said today is something very important in terms of us thinking about it.

MS ANDERSON: Thank you.

MS ABRAMSON: That would be great, thank you.

MS ANDERSON: That's okay.

PROF KING: Thank you.

MS ABRAMSON: Thanks.

MS ANDERSON: No worries.

PROF KING: We'll have a quick break for afternoon tea.

MS ABRAMSON: No, (indistinct words) we're running on a schedule. We need to have a break at 2.45.

PROF KING: My apologies.

MS ABRAMSON: So we'd need to see Mr Napoli.

PROF KING: David Napoli. My apologies for that, I misread the - - -

MS ABRAMSON: (Indistinct words).

MR NAPOLI: I don't know whether this works does it?

MS ABRAMSON: No, it doesn't work amplified.

PROF KING: Yes. No, they're purely for the transcript, they don't amplify.

MR NAPOLI: No, okay.

PROF KING: So if you could just state your name and your organisation.

MR NAPOLI: David Napoli. My company is Quattro Investments Pty Ltd. We work in a number of industries but the one I'm here today representing is our investment in mental health. I'm managing director of health practice that works in three locations. We were a multidisciplinary practice because we tried to follow the guidelines of the Australian Psychological Society and the mental health review until the regional PHN actually gave major work that we were seeking to an employee assistance provider who doesn't have any resources or services in one of the main areas we work in which is regional. And as a result of that we now focus only on psychology and that's what I want to talk about today.

A bit of background; I started off life as an academic economist, saw the errors of my ways. I've got to be careful saying that in this audience.

MS ABRAMSON: I'm not an economist so you're fine there.

MR NAPOLI: And shifted into organisational psychology where for many years I'm an adjunct - I've been an adjunct at Curtin teaching post graduate students in the Graduate School of Business. What I want to do is I'll probably build on the previous speaker's comments to a large extent and I want to take an economic approach to it if that's - I hope it will be supportive of some of the comments that she made (indistinct words).

One of the things I just would like to say at this stage though is that she was correct in talking about Medicare only reimbursing psychologists, general psychologists, for focused - I've forgotten the term now - focused therapies - - -

PROF KING: Psychological strategies.

MR NAPOLI: Strategies, that's right. But I do understand that the APS recently in its White Paper recommended to Medicare that all psychologists can do therapy so that's in the White Paper so that's what I'm told anyway. The main thing I'm going to talk about today is how to we get a bigger bang for the buck as you said in the report. A factor in achieving a more effective use of mental health (indistinct) is the need to recognise that all psychologists provide therapy and there is no evidence in the literature anyway to support that superior outcomes come from clinical psychologists, it just doesn't exist as I could see.

Therefore the two tier rebate system built around qualifications, which is an input measure, cannot be justified and not only does it distort the market but it delivers an inequity to the patients. It's elimination I'm going to argue would provide a significant increase in therapy hours for the same level of government expenditure. Now, Medicare is being reviewed and presently mental health is obviously on the agenda. The APS, the Australian Psych Society, sent a proposal to the Medicare Benefit Scheme review committee last year and most of the recommendations were agreed by the MHG, the reference group.

However, one of the main recommendations that was there was - and they couldn't get consensus on it - was the debate about the one tier rebate for the same service provided by different types of psychologists. Presently we have a two tier rebate where there is a 47 per cent difference in the rebate between general and clinical psychologists for the same service which is really bizarre. Clinical psychologists have two years extra university training in complex psychiatric illnesses which represent approximately 2 per cent of the mental health illnesses that we face however clinical psychologists have been attending to general mental health illnesses since 2006, now called Level 1 and 2 in the stepped care model and receiving a higher rebate for the same service that general psychologists are registered to provide. In the literature it doesn't support that the outcomes between the two are any different and I can give you the reference if you like?

PROF KING: Yes, please. We'll take it offline - but, yes.

MR NAPOLI: Yes, okay. Now, general psychologists can also include those with Master's degrees in a related field but they're not classified as clinical psychologists and they can have doctorates and they can have special training in areas like ADHD, autism, borderline personality disorders, PTSD and so on. Now, I want to share a sort of living example for you in a practice that I'm very familiar with. In one case we've got - one of the psychologists that I'm referring to is a clinical psychologist recently granted clinical registration after completing a Master's degree in clinical psychologist and supervision and the other general psychologist with a PhD based on research in adult autism and is seen by the world as an expert in the field and has done two TED talks on the work that she's done.

Now, the mental health practice charges a standard rate for the service as most do. Now, patients that have conditions that fit Level 1 and 2 in the stepped care model are seen by a clinical psychologist and they receive - I'll use the figures, the old figures, 124.80, because they're the figures I used in the submission and I don't want to confuse. I know that they've been increased by about $2 recently.

PROF KING: Yes.

MR NAPOLI: But I'll stick with those because it's the difference that's important.

PROF KING: That's fine.

MR NAPOLI: Obviously patients will make an economic decision and seek help from a clinical psychologist even though the person is less qualified and less experienced. Now, this two tier - well, see, the general psychologist the rebate is $84.80 so why would you actually want to go and see a generalist if you're stuck for a dollar when you can get a much higher 47 per cent more rebate by actually seeing the clinical psychologist? Now, that actually distorts the workload in the practice and it actually distorts the government (indistinct) and I'll talk about that in a minute.

This two tier rebate clearly distorts the market and the consequences for the government is that expenditure on rebates is much higher than necessary because they're actually paying for extra that they shouldn't be paying for. Many more patient hours could be supported by the same level of government expenditure by eliminating the two tier rebate that's based on inputs and that input is a very narrow field which is a Master's degree in clinical psychology.

A business owner who would want to offer bulk billing, and because one of our practices is in a poor socioeconomic area with high levels of substance abuse and high levels of unemployment, so we would actually like to offer bulk billing but we - and to do that we're forced to employ only clinical psychologists. The difficulty is we can't get any in regional areas so we're really stuck. In Mandurah we cannot actually find - we've been trying for 18 months to recruit a clinical psych and it just can't be done. And the business actually is not viable on $84.80 per session.

The two tier issue has caused a serious divide in the profession. Thousands of concerned psychologists wrote personally to the health minister as they felt the Australian Psych Society was not supporting them. It was the only way they felt heard. However, the government indicated that they weren't interested in solving or being involved in the debate but it was actually the government's policy that caused the issue so he was a Pontius Pilate there wasn't he. So I suspect that's why the thing was handballed to the Productivity Commission to solve perhaps.

The APS informed Minister Hunt that they would come up with the solution via a consultative process over several months with its membership and other stakeholders led by an internal APS committee. However, they couldn't come to consensus either about the single tier rebate. As a result the issue was passed on to the APS board which is imbalanced in its membership with five clinical psychologists and only two general psychologists. So you did mention something about vested interests but I'll sort of let you mull on that - although the general psychologists in the APS represent 16,000 out of the 24,000 members so that's an interesting distribution of power in the system.

It's understood that the board obviously, and it operates on majority votes, so the board endorsed the White Paper that the APS had written and it was clearly in favour of the clinical psychologists and supporting the current system where there are vested interests. As managing director and business owner of a mental health service the White Paper's inequity for clients troubles me greatly with the proposed difference - they're proposing, I think it was, $170 for clinical and $100 for general psychologists. Well, that's now a 70 per cent difference between general and clinical psychologists and they've now introduced something called 'areas of practice endorsement' where you can actually specialise in something and then I think it was in counselling, I'm not too sure on that, where you could actually argue for the same rebate as the clinicals so - and it's proposed that they are specialised in certain areas around Level 3 in the stepped care model.

But many general psychologists have many years of training and experience and deliver good outcomes from what I've seen and experienced however these AoPEs will also continue to provide services at Level 1 and 2 but also they will attract the higher rebate on those levels so there's an equity issue there. This would be akin to a medical specialist working in a general practice attracting specialist's rebates. It simply doesn't make sense that the government has allowed this to happen and continues to allow it to happen. This inequity has cost the government millions of dollars and caused clients less opportunity to seek the services they need.

Low income families tend to avoid seeking mental health support because they can't afford the gap and cannot approach the PHNs because to approach the PHNs you've got to be unemployed so they're low income but they're not unemployed so there's a gap there that I think would be useful to be addressed. Now, this has caused several problems over the last 13 years since Medicare for mental health was introduced in 2006. Is the Medicare rebate based on years of formal education at a university, in other words inputs? And because one of our psychologists, our senior psychologist, actually is a specialist in autism and ADHD we were hoping to train another psychologist up to that specialty to apply for AoPE at the University of WA and they've got a course in autism but the interesting thing is that it's not recognised so the university's out there selling courses that the system won't accept so it's a major issue.

So, you know, clients who are under financial strains seek to see psychologists who attract the highest rebate obviously and it distorts it. As a result clinical psyches have a heap of work and a long waiting list. General psyches, some of them struggle to fill their books so, you know, we're not making use of the investment and the public cost that's gone into the education of all psychologists. Clinical psychologists can bill as their rebate's 47 per cent higher and generals can only do it at $84.80 and we've calculated that our costs of running the practice are about 60 per cent so it leaves $33.92 per hour long session and you just can't employee a psychologist for that - you know, we'd be losing money.

PROF KING: I'm just conscious of the time, Mr Napoli.

MR NAPOLI: Okay.

PROF KING: So if you could - - -

MR NAPOLI: All right. Cost to the government: well, I'll just jump onto that. Look, three solutions I see. If Medicare for some reason and with no evidence consider AoPE's outcomes are superior then clinical and AoPEs worth with Level 3 only and they work in that area of Level 3. The clinicals and the AoPEs see Level 3 at the higher rebate and if they work at the lower rebate they go on the same rate.

PROF KING: Yes.

MR NAPOLI: The preferred position is that all psychologists work over all levels and all are trained and registered by AHPRA and - yes, what's the - the Psyche Board, and all psychologists should receive the standard rate for all work and they all should do therapy basically so that we capitalise on it now. In the submission I put through I actually talked about the numbers and the economical model and if we look at - - -

PROF KING: Sorry, we would have that, so.

MR NAPOLI: Yes, one million hours, one million consulting hours, the saving if instead of 50 per cent of the model while 50 per cent of clinical psyches do 500,000 hours, general psyches to 500,000 hours at the different rates. Now, if they were all on one rate, even the clinical rate, the saving would be - sorry, all on one rate the saving would be $43m to the government so that's in my formal submission.

PROF KING: Thank you, Mr Napoli. Can I ask, because the model we envisage in our draft report is essentially changing the client base for psychologists and in a sense shifting that workforce to higher level steps so people with mild anxiety and depression in particular but more mild psychological or mental health issues would be seen by less intensive therapy and a variety of alternatives that could be available there. So in a sense we suggest a solution which is a bit like your Level 3 only psyche approach but we would see all psychologists moving down there. Do you see a problem with that? What would you think would be a reasonable rebate for that level of intervention for those particular clients - sorry, for seeing those particular clients with obviously an expanded range of psychological therapy?

MR NAPOLI: Well, I'm going to answer the question indirectly. I understand the upper rate was set for clinical psychologists because when clinical psychologists started work years ago they worked in a hospital or in an institution and worked in association with a psychiatrist and they worked on people that were dysfunctional and obviously couldn't work and often low or no income so they had to be rewarded appropriate for that because they had no other avenue.

I actually am not sure what the levels should be but, you know, if you looked at the - you know, put the two rates up as they are today, 85 versus 125, it might be somewhere in the middle, but even at $100 rebate a business would be struggling with its costs at 60 per cent because it means that you're looking at 40 an hour. I think realistically my answer should be you should be looking at about $125 an hour rebate.

PROF KING: Okay.

MR NAPOLI: Yes, to keep the business viable and to keep people active in it.

PROF KING: Okay?

MR NAPOLI: Okay.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you very much.

MR NAPOLI: Thank you.

PROF KING: And let's take a quick break for a cup of tea. If we can come back at three o'clock would be good.

(Short adjournment.)

PROF KING: Let's recommence. Professor Hillman, if you would be able to state your name, organisation that you're representing and any introductory comments.

MR HILLMAN: Right, I'm David Hillman. I come in my capacity as a sleep physician and researcher but among other things I was past president of the Australasian Sleep Association which is the peak national professional body for sleep clinicians and researchers and founding chair of the Sleep Health Foundation which is the leading national advocate for sleep health. I appear here because of my concern about missing information insights in the draft report regarding the close links between sleep health and both mental health and productivity and this concern is, we were remarking before we started now, is highlighted by the observation that while the draft report concerns itself with mental health the word 'sleep' doesn't appear at all in its 34,000 word overview or in any meaningful in a mechanistic sense in the other 457,000 words.

I'd like to just make the point that there's a substantial common ground that exists between poor sleep and mental health and I was just going to give you a running list of examples of that. They're all referenced and I'll provide those references to your staff subsequently.

PROF KING: Thank you.

MR HILLMAN: Forty per cent of people with insomnia that has difficulty achieving or maintaining sleep have comorbid psychiatric conditions. Insomnia is associated with depression, anxiety, substance abuse and suicide. There's a strong relationship between the presence of insomnia and the subsequent onset of depression within the next one to three years. Individuals with insomnia and no previous psychiatric history are at increased risk of new onset major depression, panic disorder and alcohol abuse.

In our adolescents 69 per cent of cases of comorbid insomnia and depression insomnia occurs first while in 73 per cent of cases of comorbid insomnia and anxiety, anxiety occurs first. So these things operate in different directions. Adolescent who commit suicide have higher rates of insomnia in the week preceding death. When we look at depression, the links between depression and disturbed sleep are bidirectional and depression disturbs sleep, disturbed sleep aggravates depression. Clinical depression and common sleep disorders share symptoms. Sleep apnoea and depression are an example. Now, if you look at the patient health questionnaire, a common questionnaire for depression, questions come up - there are sort of nine questions and they're along the lines of little interest or pleasure in doing things, feeling down, depressed or hopeless, trouble falling sleep or staying asleep or sleeping too much, feeling tired, little energy, poor appetite, overeating, feeling bad about yourself for a failure, trouble concentrating, moving slowly or excessively restlessly, thoughts about being better off dead or of self-harm.

Now, that is a list of symptoms that fits pretty well for a lot of sleep disorders that I know and so there's a potential there for misdiagnosis. Fifty-two per cent of the patients coming to our sleep clinical at St Charles Gairdner Hospital in Perth arrive on antidepressants. Now, the average use for adults in the general community is 9 per cent. Not surprisingly given all this obstructed sleep apnoea it's particularly underdiagnosed in depressed people and there's literature referring to that. And furthermore if you treat the obstructive sleep apnoea the depressive symptoms remit.

We look at suicidal behaviour. Sleep disorders particularly nightmares and insomnia are associated with suicidal behaviour in depressed patients. With psychotic illness; the links between psychotic illness and disturbed sleep are also bidirectional so sleep disturbance is common in schizophrenia and is also associated with increased symptom severity, neurocognitive defects and reduced quality of life. As with depression, psychotic illness and sleep disorders share symptoms so the (indistinct words) that group of sleep disorders characterised by unusual behaviours at night, panic attacks, violent dreams and the like are often confused with psychiatric disorders as is narcolepsy. So narcolepsy, one of the symptoms of narcolepsy is dreaming at sleep onset and offset and this could be misinterpreted as hallucinations and diagnosed as schizophrenia so there's a potential for misdiagnosis there. Of course the drug effects used to treat various mental disorders have effects on sleep, commonly sedation but occasionally insomnia.

The links between disturbed sleep and behavioural issues are biologically plausible and they're plausible in part because the frontal lobe that centres the response for emotional modulation are particularly sensitive to disturbed sleep and I guess these potential links are reflected in the common experience of us all so poor sleep is associated with irritability and impaired decision-making and we would all recognise that from our personal experience.

The associations are strong, cause or effect - you know, the good long general studies, there's a gap there and more needs to be done. That's important but it's not absolutely vital and what can be said is that poor sleep is a symptom of mental health, ill health. Poor sleep can be prodromal to mental ill health and there's some good evidence that poor sleep is the causative factor in mental ill health. And where these associations are not understood then diagnostic confusion occurs and mismanagement can occur. Adolescents and young adults are of particular concern, concerns about the disengagement, concerns about lost learning opportunities, concerns about behavioural problems. Can these issues be safely ignored? Well, I think not. Inadequate evidence is not the issue here but inadequate examination of the evidence could be.

So just in concluding, a few suggested actions. I think from the report's point of view factoring sleep health into the preventable and therapeutic advice offered by the report's important. I think also this report presents a marvellous opportunity to provide some resonance to the recent parliamentary inquiry into sleep health awareness. Now, that report was tabled in April 2019 available on the internet and amongst other things it recommended in its recommendation 8 a national sleep awareness campaign with mental health and productivity mentioned amongst the specific objections. It's recommendation 9 recommended developing effective training mechanisms to improve the knowledge of primary health care givers, GPs, clinical psychologists, dentists, ENTs et cetera in diagnosing and managing sleep health problems.

So while this knowledge is developing very well within the specialty of sleep medicine and there's a huge literature out there, generalising this knowledge is one of the opportunities that I think the Productivity Commission has. So the inquiry has the opportunity to highlight these risks and in so doing increase community awareness of them and promote actions to counteract them with substantial potential benefits for communal health wellbeing, productivity and I might say a massive economic benefit that can flow from that as well. Thank you very much.

PROF KING: Thank you very much, Mr Hillman. If I can just lead off. So, as you say there's an issue of diagnosis. One of the interesting things that in general within mental health there seems to be issues of misdiagnosis but particularly with regards to misdiagnosis for depression and you mentioned the figures on people coming to St Charles Gairdner who are on medication for depression which probably goes back to GP diagnosis. How do you change that? Is it as simple as an education campaign or is it changing the curriculum for training of GPs or how would you help move this problem?

MR HILLMAN: Well, I think from the perspective of sleep, it's increasing knowledge about sleep and the amount of sleep education that the average undergraduate gets around the country is measured in hours and we've done something about that locally recently. So increase in sleep education but increasing the awareness of the diagnostic possibilities that depressive symptoms represent so I try to be very careful when talking about in distinguishing in my own mind between clinical depression and depressive symptoms. So in my world, (indistinct words), I see depressive symptoms a lot, a lot. Not quite universally but almost. I see people with clinical depression a lot less. I see a lot of people have been diagnosed with clinical depression who have sleep disorders (indistinct words) in that sense and so I see the results of misdiagnosis.

If I go to narcolepsy interestingly I remember - if I may just give you an anecdote to give you an example, a young woman aged 18 who had clear narcolepsy. She had the sleepiness of narcolepsy, she had the episodes of sleep paralysis overnight. She had the vivid dreams at sleep onset and offset which were in the leading edge of her problems and she was diagnosed as having schizophrenia at the age of 14. So through all her developmental years, those important development years, she had this diagnosis which is a difficult diagnosis to live with and a difficult diagnosis to acquire an education by and of course it is ongoing untreated symptoms of narcolepsy.

So with a diagnosis, which was pretty obvious, clear and a few treatments later she had found a job, next visit education and next visit changed life and no visits since then because she's returned to GP care but the point I'm making is that if you get these diagnoses wrong you set in train events particularly for teenagers and adolescents that affect the rest of their lives potentially, so I think better education. But in my world better education about sleep is absolutely vital and making sure that depressives symptoms aren't immediately given a label of clinical depression that they're treated as symptoms with a range of potential causes.

Of course DSM-4 and 5 recognise that. They look for other causes for these symptoms to be excluded and I don't think we're good enough at doing that.

MS ABRAMSON: No, no, as I was saying to Professor Hillman, we took a lot of note of his colleague's evidence - - -

PROF KING: Okay. Well, I've just got one more question then. Children: actually I haven't connected with this inquiry because I happen to know someone who has obstructive sleep apnoea and so I've been looking at a bit more on sleep myself. Children at risk; so as I understand it there's issues with regards to children, teenager's sleep and again the issues of not getting the right amount of sleep and the consequences of that. Anything we should know about that?

MR HILLMAN: I think it's a really - it's a big problem. I went to a teacher's conference in Perth last year and I presented to this group of concerned teachers and the impression I got from what they told me they were very concerned and kids arriving at school needing two things; needing their breakfast and needing a sleep so inadequate sleep for a variety of different reasons. Of course one of the features of poor sleep in children and adolescents is sometimes it doesn't present as sleepiness so much as behavioural difficulties and so behaviour difficulties, disruptive behaviour and inability to give their learning tasks the attention they need.

If you look at sleep apnoea in children, untreated sleep apnoea, they fall behind in their schooling, they treat their sleep apnoea and they catch up all right but there's some evidence to suggest that if you leave it for a long time (indistinct words) developments measurably change so they don't - well, they catch up, they never get to quite the same point. So these developing brains I think sleep disruption is a big deal, sleep disruption from whatever cause from a mechanical cause like sleep apnoea but also poor sleep habits because of gaming and all these other distractions that kids now have and some action's required and the teaching professional is concerned about it, we're concerned about it and we intend to work together on the problem.

PROF KING: Okay, thank you very much.

MS ABRAMSON: Thank you very much.

MR HILLMAN: Thank you.

PROF KING: Next we have Dr Joseph Naimo. And if you could state your name and any organisation you may represent and any initial comments you'd like to make.

MR NAIMO: My name is Joseph Naimo. I'm an independent though I am associated with the Australian Association of Professional Applied Ethics and I am a member of the School of Philosophy and Theology at Notre Dame. So my interests are research wise but I'm also a family member of an autistic young man and so I'm concerned about his welfare and I'm just going to get my notes if I may please. And the two points that I would like to address today - is that right, do you have it?

PROF KING: No, that's fine.

MR NAIMO: Okay, because you looked a little bit inquisitively there and I thought maybe - - -

MS ABRAMSON: I'm sorry, we're just trying to juggle a few people but you have our full attention.

MR NAIMO: Thanks very much, I appreciate that. And thanks for the opportunity. So I want to talk about plenary guardianship, the substitute decision-maker, and the concern that I have about restrictive practices. I did want to say that to guardianship, when there's an individual who is incapable of making decisions for themselves and we're talking about life, real life decisions not every day incidental decisions about, you know, which apple to you want or whatever it might be and essentially when power is put into the place of one individual the tendency is that it will corrupt at some point so absolute power we know, as Lord Acton wisely advised - and so I'm recognising in my experience the safety mechanisms to avoid that kind of abuse that might occur are found wanting and it's having a diabolical effect on my life and also others but more so detrimentally to my family member and so it's systemic so this is why I wanted to at least point out what I've recognised and what I've managed to also learn from those in the community that are having similar concerns which I didn't think was addressed in the draft and I don't think that it's been addressed by the Productivity Commission so I wanted to at least be given the opportunity to raise these concerns.

PROF KING: Yes, please.

MS ABRAMSON: Mr Naimo, we're very interested in what you have to say. I happen to be a lawyer by training and we certainly looked at representation before mental health's tribunal but you're quite correct. We didn't really look at any of the guardianship issues so I would welcome your comments on that.

MR NAIMO: Thank you very much. For those that perhaps don't know I might at least explain what guardianship is and how it operates under the Acts.

MS ABRAMSON: And that's under the West Australian Act because they're State based.

PROF KING: Yes.

MR NAIMO: And this understand the West Australian Guardianship and Administration Act of 1990. Now, the Attorney General reviewed in 2015 and made some recommendations. So essentially what I want to talk about is (indistinct words) recommendations the power that's extended to the individual, the guardian, I think it's excessive particularly if it can cripple those governance institutions that, you know, who's job, duty of care, in terms of oversight is to ensure and safeguarding of vulnerable individuals and - - -

MS ABRAMSON: Do you think it occurs at two levels? Is it in the application for guardianship, are you thinking that that's applied too readily or is the other end, the sweeping powers that guardianship would bring with it?

MR NAIMO: Well, I think both and I think it occurs in both cases because the only way that you can apply or you can minimise the power and the exercise of that power and how it can corrupt the individual because, look, there's no opportunity for advocacy, there's no opportunity if you want to raise a concern, if the guardianship chooses not to hear that concern there's nothing you can do.

MS ABRAMSON: Is this where the guardian is the State as opposed to an individual?

MR NAIMO: No, no, it's an individual. Now, if it was a State through the Office of the Public Advocate that might be a different thing.

MS ABRAMSON: Yes, that's right because there are processes - - -

MR NAIMO: And there are processes and elongated so there's a greater concern there also. In terms, and if I may go back to these recommendations because it does raise concerns about the power particularly when it comes to experimental sort of treatment, restrictive practices, that is authorised if the guardian gives consent and irrespective of the individual not wanting them and the harm that might be caused to the individual then that is matter of concern. Our civil duty is to ensure no harm unintentionally or intentionally is perpetrated on the individual and that's my concern here because I've watched my family member's life deteriorate dramatically and, do you know, nothing has been done, it's falling on deaf ears.

MS ABRAMSON: So your family member's become the subject of a guardianship order?

MR NAIMO: No, he was the subject of a guardianship order from when he was 15, he's really autistic. And so the wrong diagnosis started when he was a very young lad, you know, at three and a half. He was highly medicated far too early, traumatised and the conditions where he is now with the service provider, and I won't mention the service provider, but, you know, isolation sections, polypharmacy to a large extent, he - you know, 120 different involuntary ECTs, in excess of 140 different support workers within a three year period. Now, any rational person would question and would take note of what's happening.

MS ABRAMSON: And are you unable to advocate for him because someone else has been appointed as a guardian?

MR NAIMO: Another family member.

MS ABRAMSON: Okay, I understand.

MR NAIMO: And we've shared the responsibility throughout but the last four or five years have been increasingly difficult and an increase in the distancing. The challenge is that the perception is that if you are challenging that it is damaging to one's capacity or it appears as a threat to one's capacity to make decisions on behalf of a loved one. But essentially what happens is there's a dynamic that changes as you progress and the more and more you're thwarted and the more and more you appeal to the agencies who's, you know, duty is to safeguard the fracture increases and the chasm increases and it makes it - - -

MS ABRAMSON: Are there no staging points in the guardianship process because if it's a public advocate, for example, it has to come back before the mental health tribunal or whoever at certain staging points so if someone is appointed as a guardian under the Guardianship Act is there no review mechanism for that?

MR NAIMO: Well, you can but you're dealing with the same people and you're dealing with the same investigators and of course what happens is that if the guardian does not want the investigation to go ahead they must defer to the guardian. If the guardian gives consent investigations stop so I think I've exercised every option; AHPRA, HaDSCO, I've gone through them all and I'm getting these dead ends and essentially they defer back to the authority. Now, the individual doesn't have medical expertise, the individual doesn't have management experience so the individual depending on who - and irrespective of my family member, but essentially this power that is bestowed upon an individual; where do they get the common sense or where do they get the information from to make judgements on behalf of an individual who is incapable.

MS ABRAMSON: Can I say two things. First of all you mentioned that the Attorney General made some recommendations that may have improved the circumstances that you're talking about?

MR NAIMO: They actually didn't and the recommendations were recommendation 24 and 25 of that and can I read to you recommendation 25: 'That the Guardianship and Administration Act 1990 is amended to provide that the role of the preliminary guardian can also include the authority to make decisions regarding the restraint of the representative person including in relation to making decisions about chemical and physical restraint and then on top of that consent to medical research, experimental health care and clinical trials.

MS ABRAMSON: One of the things I would say is that we've been very interested in the legal advocacy support or advocacy support for people appearing before mental health tribunals but we have not thought of it in the context that you're talking about in terms of guardianship so that would be an area where it might be possible, I'm just thinking out loud to be honest in responding to you, where you might say that, 'Well, actually that young person, the person concerned, needed to have an advocate who was neutral' for want of a better word.

MR NAIMO: And I think often times that might be a better starting point.

MS ABRAMSON: I'm not talking about your personal circumstance.

MR NAIMO: No, no, and I appreciate that and I think that was the role of the Office of the Public Advocate and my understanding is, and I might be incorrect here, but they assume guardianship for some 30,000 individuals in Western Australia alone so that's quite a lot. Now, what concerns me as an ethicist is that if we're talking about individuals under the care of, you know, an organisation or an institution like the Office of the Public Advocate, they have essentially in my eyes turned a blind eye to my family member's treatment. What about these 30,000 individuals that are in their care?

MS ABRAMSON: It might be, and as I said it's not my area of expertise but we will have a look at it, it might be something about the public advocacy process that they cannot act in circumstances where a guardian, you know, another guardian - I don't know the answer.

MR NAIMO: Well, there's two types of guardianship; limited might only - you know, family's still involved somehow; and then there's plenary. So plenary has the absolute power, so much power that it can remove another family member out of the picture and ensure that family member might have some, you know, visitation like one hour at (indistinct words) which I get of a Saturday now because I've, you know, been raising hell and essentially the guardian has the power to do that. So I think sovereignty is lost here. A voice of another family member is lost - I'm out of the picture as if I have nothing of value to add.

MS ABRAMSON: I don't sort of want to put you on the spot about your personal circumstances but I take the point more generally about the interaction between the Guardianship Act and the Public Advocate and the person who has the treatment and there's a lot of conversations that people have had with us about the capacity of people to make decisions for themselves so we'll have a look at it.

MR NAIMO: And it's really important I think because that in and of itself - there are two types of model; one that's fluid so there's opportunity of recovery and can develop so hope is invested in that. The other model is static; so when you've got particular service providers whose funding is reliant upon dependency, you see, that in and of itself will breed a certain attitude where you maintain these clients and they have to be in that static because this guarantees income. So if you've got these service providers that are training on that business plan then essentially what's happening to the individuals because most of them I guarantee you will be overmedicated.

MS ABRAMSON: Look, we really do take on board what you've said. I don't know where that would lead us but I can say that we will - - -

PROF KING: Yes, thank you very much for bringing to our attention something that we had clearly overlooked and that's really important.

MS ABRAMSON: And if you could leave your details with one of our staff that would be very helpful.

MR NAIMO: Thanks for the time, I appreciate that.

PROF KING: Thank you. Michael Finn. And if you could identify yourself, if you're representing an organisation your organisation and otherwise if you'd like to make any opening comments.

MR FINN: Thank you. My name is Michael Finn. I come here as somebody with an interest in mental health. I have a background of having commenced nurse training in 1971 so I'm one of the dinosaurs of the system. I've been around long enough to see the cycles reoccur and it's the review of the Productivity Commission's draft report that leads me to want to make some comments on some areas.

Just to give some background to myself: I'm a fellow of the Australian College of Mental Health Nurses. I sat on the board of the Australian College of Mental Health Nurses. I'm currently a member of the board of Investing In Our Youth in Bunbury, Western Australia. I sit on the board of the Riding for the Disabled Association in the Bunbury region. And I'm a former chair of Advocacy Western Australia which is a regionally based advocacy NGO. I hold several qualifications in nursing and education and over the years I've been involved in child and adolescent, adult, inpatient community-based services and a variety of other activities that give me some insight into what occurs across mental health services. And I'm currently also a technical expert for JAS-ANZ and JAS-ANZ is the accreditation body that accredits certification bodies who register organisations for the NDIS. So it's a fairly broad background there.

The Productivity Commission's draft report, I know it's had its genesis in the issues paper that was issued back in January, and some of the things I was interested in from that and from the actual report that you've now produced is that there seems to be a bit of a draft and I don't mean this in any disrespectful way. If you look at the first two key factors identified in the report that drive poor outcomes in Australia's mental health system, the first two key factors are the underinvestment in prevention and early intervention and that there is too much of a focus on clinical services. I mean no disrespect but I believe that this report has insufficient emphasis on the benefits of the promotion and instead has continued a heavy focus around clinical and treatment services and I think that deviates away from the importance of the activities that support mental health promotion in the community.

And activities that support mental health promotion in the community don't necessarily have to have a clinical basis or necessarily a focus on mental health itself and I'll give an example of what I'm referring to there and that's back in the early nineties I was involved in a project (indistinct) Martin Seligman's work at prevention depression in children. This was a project that was funded under a reset grant with Graham Martin from South Australia Child and Adolescent Services and Bret Hart who is a public health physical with a very strong emphasis in prevention programs.

The project gave rise to what's known as the Aussie Optimism Program which is about positive thinking skills which is a school-based prevention program developed by Curtin University and Curtin University were a partner to this original project. So Aussie Optimism is an evidence-based mental health program that is aimed at children in primary and lower secondary schools. It's based on Seligman's theories of learned helplessness and more generally on positive psychology. As such Aussie Optimism focuses on building competencies in children rather than alleviating problems and this is the ounce of prevention worth a pound of cure argument as we get into early intervention programs and I have a lot of involvement in developing early intervention programs and reviewing them, the horse has bolted. We're already starting to have to draw back on some of the things that have occurred by way of damage to young people.

Aussie Optimism is designed for teachers to use in a whole class in school over a term at one section a week. The program can be incorporated into basis curriculum so it's not a treatment, it's not an intervention and it's tailored for children from years four to eight so it's about the time when thinking processes are starting to change moving from concrete operational through into abstract thinking and it's around attributional styles. Seligman's early work spoke about negative attributional styles being the genesis for depression so the theory underlying this is if you can start to develop positive attributional styles that would then immunise against depression. Bret Hart was very strong on the immunisation stuff as a public health physician.

So teachers would attend a one day straining workshop for each version of the program and the program isn't badged as mental health focused yet has clear mental health promotion gains and this is recognised if you look at some - the Black Dog Institute website. It's one of the programs that's identified as recommended for not so much early intervention but for protective behaviours. Aussie Optimism teaches practical skills and strategies that relate to social and emotional wellbeing in children and makes use of empirically validated psychological and educational techniques.

The content for the program is developmentally appropriate for children of different ages and it's been extensively evaluated since being developed in '97. Research indicates that Aussie Optimism, which is the Australian sort of version of this, reduces mental health difficulties. It increases prosocial behaviour, it reduces the incidents of suicidal ideation and behaviour, it increases recovery from suicidal ideation and behaviour and increases recovery from depressive disorders and it reduces the likelihood of drinking and smoking at later stages so there are some other health benefits that arise from that.

So there's evidence of other health improvements around reducing the rates of stress-related disorders, obesity, diabetes, cardiovascular disease and other physical disorders all of which have a significant impact on the quality of life as well as a growing cost impact on the Australian economy. Those sorts of programs seem to have largely been overlooked in this report when I talk about health promotion. The focus is on more early intervention which is not in itself health promotion so I would encourage the Commission to give greater weight in the reform area, number one, to supporting direct and indirect health promotional activities and school curriculum inclusions that target children to develop resilience which in turn offers the possibility of life long and intergenerational protective benefits.

I don't know if Curtin University is actually engaged with the Commission but I would suggest that Aussie Optimism might be a consideration for addressing the information request 3.1 for educational activities that support mental health and wellbeing and it's not the only one that's out there but I would strongly suggest that those things be given greater consideration. They access children at early stages of development, they offer protective behaviours, they're cheap. And they're much cheaper than treatment.

I'll just talk a little bit about the integration of services and this is about draft recommendation 10.4 on the care coordination services. This is focused around people with severe and persistent mental health issues and I'll quote here that the Commission recognises that: 'Consumers with the most complex mental health needs should have both a single care plan and a dedicated care coordinator who works alongside the clinical team to oversee the implementation of the plan'. Well, in practice this is difficult to achieve when a person may not be connected to a mental health service and we're seeing lots of people who are managed by their GPs who have very frank mental health issues but don't have a diagnosis or don't wish to be connected to a mental health service or in fact may lose themselves to a mental health follow-up and it's often the case that these people are also accessing multiple community based resources (indistinct words) non-clinical resources.

Often these individuals have substance use comorbidity and don't meet the threshold for admission to a mental health service or the allocation of a case manager but these people are there, they're real, they consume huge amounts of resources. While the Commissioner supported the development of single care plans for some consumers the lack of a dedicated case manager system is a far more pressing issue for people who might have persistent or severe mental illness and there's lots of people who have got all different manners of behaviour problems that lead them into strife.

This especially true of people who are not connected to a mental health provider and where there is no lead agency that will take up the role of care coordination and in these instances the problems often fall into the psychosocial domains being such as tenancy risk, inability to negotiate complex bureaucratic processes, relationship issues, child protection and other social aspects of their lives. Now, I'll give an example of some of the issues that were encountered in the advocacy area. As a board member for Advocacy WA I too often heard of the issues presented to the service advocates of individuals who might have involvement with up to 13 different agencies or providers but with no lead agency, services often duplicating one another and a lack of communication between the services and when you consider a lot of the clients that we're talking about are itinerant so they can be very mobile.

This results in the person becoming increasingly distressed to the point of behaving erratically or committing offences in order to achieve some form of resolution and that resolution in their eyes could be admission to hospital or in fact committing an offence to get arrested so then go to prison and get the roof over their head. These individuals if not well managed consume significant health, social and policing resources. If not already then these individuals become locked into a repetitive cycle which contributes to them becoming a part of the persistence of early mentally ill cohort.

Now, what I'd encourage the Commission to do would be to expand the scope of the draft recommendation 10.4 to incorporate provision for individuals in the community who may present with complex psychosocial issues and/or may be frequent service users or have multi-agency involvement and if you go to any emergency department and ask, 'Who are your frequent flyers?' they'll fit.

MS ABRAMSON: We understand.

PROF KING: Yes, understand, yes.

MR FINN: I'll move on now to some workforce issues that I have. The original terms of reference said that employers not for profit organisations and carers also play key roles in the mental health of Australians and that was very prominent in the terms of reference. While I wish to address the non-clinical unregulated workforce issues I'll make one comment regarding draft recommendation 11.3 which is around more specialist mental health nurses so I'll just start with that.

As an older nurse who's worked under the old apprentice based system, the nurse training system, through to the shift in nurse education, the tertiary sector, and as an educator of undergraduates, postgraduates and an employer of nurses who have been prepared for nursing practice in a variety of different forms I would like to lend my support to the Commissioner's recommendation for a three year direct entry undergraduate degree into mental health nursing. As it stands, and this is something I feel quite strongly about, a comprehensively prepared nurse can graduate from a university program with as little as ten days total practical experience in mental health.

This nurse will be eligible to register with AHPRA as a registered nurse and with no pun intended - sorry, and would be eligible to work in any health setting. No one in their right mind, and there's no pun intended there, would let a new graduate loose in any high acuity medical setting yet when we look at mental health settings, all of the mental health settings, almost all of the mental health inpatient units, are in fact acute care settings which often deal with the most highly disturbed patients and yet this is where new graduates can be and are placed as beginning practitioners. Now, I've got concerns about that because often it's the case that these people are being placed into these areas that they don't have the right skill mix, they are challenged, they are unable to provide the type of support to the level that they require it and they place themselves and others at risk. So I can't emphasise enough the need for the direct entry programs.

Now, I did watch some of the Melbourne telecast of some evidence that was given so as a fellow of the Australian College of Mental Health Nurses and with extensive experience, as I've previously stated, I stand in direct opposition to the person who recently addressed the Melbourne public hearing around his objections to the Commission's recommendation. I would also suggest that if the Commission was to undertake a straw poll of nurses working in mental health that there would be overwhelming support for the three year entry undergraduate degree into mental health nursing. Okay, so that's my bit for the registered nurses.

So although preparation for an expected role isn't confined to nursing, throughout my career I've been closely involved with the regulated and unregulated workers and it's the latter group around which I have concerns. I include here in addition to mental health, and I know this doesn't fit under the remit for this particular inquiry, but I'd also include the aged care and the disability sectors as these sectors overlap on one another in competition for the pool of available workers especially in regional, rural and remote parts of our country. Now, I spent the last ten years living in the regional areas so I'm sort of fairly familiar with the shallowness of the pool of available workers.

Now, as far as government services go there's an increased pull back on delivery of direct care services to people who don't require expert clinical services so there's an increasing reliance by government on the role of the NGO sector which traditionally and historically was the realm of the not for profit benevolent societies or family support associations. No longer is this the case as for profit organisations view mental health, aged care and disability sectors as viable areas for growth and profit making. Now, I'll revisit that in just a few moments but to give some example of the sale of the growth: in Western Australia the State mental health plan modelling shows the hours of community support required for mental health clients will increase from 842,000 in 2015 to 5.29 million hours in 2025. Now, that's a sixfold increase in workforce requirements the bulk of which will be provided by the NGO sector yet the workforce plan has little focus on non-clinical staff, the ones who will be the bulwark of community support workers.

Now, the report itself here talks extensively about the various categories mental health clinical providers. There is no mention, just as with the sleep issues, of the unregulated workforce yet it's the unregulated workforce which is the biggest growing workforce in the country. Research from the Centre for Future Work in Australia Institute has identified from both Australia and internationally from the disability support sector and from other human service industries demonstrates conclusively that high quality support services are dependent on high quality employment standards and training for those who provide those services. People who work in the mental health are identified as amongst the major strengths of the mental health system.

National practice standards have been identified for the professional groups involved in the delivery of mental health care and other disciplines and workers though who are key elements of the mental health workforce may also find these standards useful.

MS ABRAMSON: Mr Finn, would it be helpful perhaps if you could spell out to us who are the unregulated workers?

MR FINN: Yes. Unregulated workers are people who can just walk in off the street, they may have no qualifications at all, they may have life experience, they don't necessarily fall in a category of peer workers, right, they are people who provide support in the community to someone who's got an identified care plan and who requires - and it's often the case it's community inclusion or home support, can be domestic support, there's a variety of different levels of support that are offered.

PROF KING: Can I ask then - okay, so I take your point on that and a couple of other people have also raised it but what would be the actual recommendation? Is it to bring this category of workers into requirements on training and standards or, I guess, what's the recommendation, and I agree we've missed this bit, what's the recommendation that you'd seek?

MR FINN: Well, I'll fast track to the recommendation.

PROF KING: Okay, that would be fantastic.

MS ABRAMSON: Thank you.

MR FINN: But first I'd say that failure to adequately train people places a vulnerable group i.e. people who are receiving support, are great risk.

MS ABRAMSON: Yes.

PROF KING: Understand completely, right.

MR FINN: Not only are the people providing the support not necessarily well prepared for their role but increasingly because of the thin margins that exist in funding the providers of services employ or engage lower skilled workers to provide the supervision of the unskilled workers so you have a twofold problem there.

PROF KING: Yes.

MR FINN: So there's a variety of recommendations that can come from the various pieces of research but I would put to the Commission, this is the bottom line, that there is an oversight in the workforce reform objectives recommendations where the unregulated workforce is concerned. I would respectfully suggest that this be remedied with the strengthening of recommendations within this report to address the issues relating to the unregulated workforce and is my hope the Commission would lend some support to the establishment of mandatory national minimum skillsets for unregulated workforce. So at the moment it's up to the provider to determine whether they consider someone is skilled enough provided of course they're not asking someone to perform a job that requires somebody who is statutorily obliged to deliver those sorts of services.

MS ABRAMSON: It would be very helpful to the Commission, I don't know if you intend to put in a submission, Mr Finn, if you gave us some live examples so that we could understand who these unregulated people are, in what context they would come into contact with the person?

Mr FINN: Mental health and aged care and disability clients often have complex care requirements that may include personal care, administration of medication and so on. The types of situations that I have encountered firsthand are where we've seen things like medications not being administered in accordance with prescription requirements or at the discretion of the support worker. Unqualified workers performing clinical procedures such as catheterisations, injuries from falls due to incorrect use or failure to use lifting devices, serious medical reactions due to workers not being aware of things like client allergies, the use of unapproved restrictive practices as a routine measure of managing behaviour and the failure of support workers to recognise to deterioration in clients due to medical conditions or side effects of medications, they're the sorts of issues that - - -

MS ABRAMSON: No, I understand, yes.

PROF KING: Yes, so they're the sort of things that, I mean, we've seen in a different sector - in the Aged Care Royal Commission we've seen exactly those sort of things.

MR FINN: Yes. Well, that was one of the things I was going to refer to, the fact that it's the unskilled unregulated workforce, when you look at the things that are coming up in the Royal Commissions for aged care and disability as well as the Victorian inquiry into mental health or the Royal Commission into mental health, it's about the skillset of the workers and the neglect and potential for exploitation of the people that they're providing support to. There needs to be tightening of the conditions around the preparation of people to provide those roles.

PROF KING: Okay. I'm just cognisant of time and could I join with my colleague in saying it would be great also if we could have that as a written submission because in some ways that then provides a lever for us to look at that area which, you know, I agree it's an area we unfortunately didn't go into enough.

MR FINN: I have prepared something for you.

PROF KING: Good.

MS ABRAMSON: Thank you. Would you like us to take that as a formal submission?

PROF KING: As a formal submission?

MR FINN: Please.

MS ABRAMSON: Thank you.

PROF KING: And do you have an electronic copy by the way?

MR FINN: I do, I could provide it.

PROF KING: Because if you're able to get an electronic copy to us that would be fantastic. So thank you very much for that, that was excellent.

MS ABRAMSON: Thank you very much.

MR FINN: Thank you.

PROF KING: That was excellent, thank you. Next person Jennie Fitzhardinge.

MS FITZHARDINGE: I'm not nearly so well prepared.

PROF KING: No, no, no.

MS ABRAMSON: A very impressive submission.

PROF KING: If you just state your name for the transcript and if you're representing an organisation what organisation and then any opening comments you'd like and we can have a discussion.

MS FITZHARDINGE: Great. So my name is Jennie Fitzhardinge and I'm a counsellor in private practice so I'm representing myself. Just a little bit on my background. I have a Master's in counselling from Murdoch University, I'm a member of the Australian Counselling Association on Level 4 which means that I have to have had at least six years' experience and ongoing professional development so obviously I pay for fortnightly supervision and I have ongoing other training.

The reason that I'm speaking to that experience is because it was very interesting that the previous gentleman was talking about unregulated workers because I guess it's interesting going through the draft, the overall report, there is absolutely zero mention of counsellors even though, you know, we have multiple universities around Australia charging great expense to become qualified and, you know, I've got to say my university qualification was life changing and life affirming and, you know, something incredibly valuable and I've put it to good use and I look through the report and I'm going, 'Well, that's something that counsellors could be doing and that's something that counsellors could be doing and should be doing' and also the many, many hours of my intellectual capacity and my heart that I have invested in becoming an effective counsellor is completely at risk because it is unrecognised from the government area. Nonetheless I have, you know, worked with suicidal people, I have worked with families in extreme distress and made a difference.

So, yes, I would really love to see university educated counsellors or - obviously because some of the incredibly experienced counsellors have also come through without a university education but nonetheless have done all the necessary, you know, ongoing professional development in mental health planning. Especially because I think that what we can offer is, certainly in the health giving aspect of good mental health awareness in terms of long term support there's a blanket not recognition that people are who are, you know, vulnerable to mental ill health, which is pretty much all of us, but, you know, some of us in different stages of our lives are more vulnerable than at other times often require ongoing support and, you know, studies have shown that the most effective thing in terms of psychotherapeutic support is not whether you do ACT or DBT or CBT or, you know, person centred interpersonal psychotherapy, whatever name you want to put around what you do it's the relationship that matters.

My experience of working for a not for profit that used to be dedicated to supporting family members of somebody with a mental illness, it no longer is because the NDIS broke us. I don't work for them anymore. Anyway, I'll come to that point later but the point about working - I lost my point, sorry. Yes, this preventative and long term support so, yes, it's about the relationship and my experience of working with family members was that, and hearing the stories of what was happening to their person, was that they never got to develop a relationship with their treating - you know, when they were in crisis they may or may not get accepted by the government system. They were always be accepted by the private system but they may not get the dedicated care that they could.

I was interested to hear that somebody could be called a 'mental health nurse' with ten days training. Some of the stories that I've heard about things that mental health nurses have done and the vast majority of people are incredibly dedicated and do great work but, you know, sometimes people would do things like - just say the most terrible things and if you only ten days training then you're putting that mental health nurse at risk as well.

You know, a big part of the training - you know, we counsellors get, and I'm only going to speak to the training that we get, is how to manage, what we hear, what we do, you know, how to get our own support, how to contain that and, you know, the damaging things that I hear people that haven't had in-depth mental health training and that's the OTs that get government recognition and that's social workers that get government recognition often if they haven't gone on to get that really dedicated back up is that the stuff - and GPs and teachers and anybody that, you know, is in contact with people - and policemen as well, is that they are really at risk as well when you don't have the depth of training that's required to work well in this space.

Your research shows that 60 per cent of family members of someone with a mental illness will go on to develop depression and anxiety themselves.

PROF KING: Sorry.

MS FITZHARDINGE: Yes.

PROF KING: Can I ask you, because we've heard from a number of counsellors and it's something you haven't mentioned which is why I'm bringing it up, you saw in our report as you said many areas where you think counsellors could fill gaps.

MS FITZHARDINGE: Yes.

PROF KING: A number of other counsellors that have presented to our hearings have said, 'Well, what we really need is a Medicare provider number' which suggests that what they're looking at is basically the Better Access as being the sort of approach for counsellors. I'm really keen to understand - and, you know, there are pros and cons, there are issues, there's government issues whenever you say, 'Ah, let's add another group on to the Medicare system', there are just practical issues there so - - -

MS FITZHARDINGE: But you're talking about adding another group into this by saying, you know, that you should have teachers that are trained in mental health. Why use a teacher? Why not use somebody that's actually either done an undergraduate degree or done a Master's or done, you know, years and years and years of training; why go and get another person who's trained specifically in one area and add, you know, a little bit of training here to do - - -

PROF KING: Okay, so - - -

MS FITZHARDINGE: You know, it's like you're adding an expense. Why not just - there's a workforce out there that is already doing the work, like, we're working around it. You know, we get government grants that, you know, make some things possible and not, you know, do what I've done which is, like, 'I'm getting out of that system. I'm going to, you know, make a living as a private counsellor' which means, you know, I get to do what I want to do which is the long term work which is the work that will make a difference because I developed that ongoing relationship with that person, I am a safe harbour for them to come to, you know, because outside of the private system you never know. Even in private hospitals, you know, people just - they go in and they don't know who they're going to see or, you know, the clients will say, 'I don't want to tell my story again', you know, and - so, you know, there's not a recognition of the value of long term care in the report.

So, yes, I just - look, Medicare provider numbers is something that gives you recognition. You know, even I was doing some volunteering work for a local mental health charity and I left because they said, you know, they wouldn't let me do things that I was perfectly capable of doing because I wasn't AHPRA registered and I thought, 'Okay, whatever'. You know, it seems crazy to me that, you know, people want to do this work and people want to access our services and what we're getting instead - and instead of saying, 'Okay, how can we bring this skilled group of people into the mental health system?' we're looking at patching things on teachers and, you know, it doesn't make sense to me.

PROF KING: Okay. I will just clarify it because the teachers (indistinct words) leaders in school wouldn't be mentally health trained, they're not meant to be counsellors. In fact that's the exact opposite of what we want.

MS FITZHARDINGE: Yes, but deputy principals in schools are already doing that here in Western Australia.

PROF KING: Understand. Different States do different things. They have psychologists embedded in schools.

MS FITZHARDINGE: They do have that here too but none of them do counselling either.

PROF KING: What we want is somebody with teaching experience who is able to then link in with the community services which could include counsellors and I recognise that but I guess what I'm after is how do we make - so we've heard from counsellors, we've heard their value, now we need to go to the next step to make it practical that they're part of the solution and so far we've only heard one answer which is, 'Give us Medicare provider numbers', okay, let's take that as a potential answer but is that the only answer or is there any other way that we can help embed counsellors in the system or is it - you know, are we simply saying, 'Look, that's the only door. If you don't push us through that door we have no place' which I get worried about.

MS FITZHARDINGE: It's a door that would make a huge difference.

PROF KING: But is it the only door, that's what I'm trying to get at?

MS FITZHARDINGE: It's possibly not the only door. I mean, it certainly - like, some health insurance companies recognise counsellors and some don't so, you know, there is a big value in the government's stamp of approval. I mean, you know, you've got creative people that may be able to think of another way of doing that. Where a lot of people with mental health difficulties get treated is, as the previous presenter said, is in the not for profit sector.

My personal experience of working in a not for profit sector was that, you know, they were employing counsellors or people with a Bachelor of Psychology. You wouldn't get psychologists or anybody with a Medicare number working because they just didn't pay enough, you know, so by default you're kind of sacrificing us on the not for profit pile because, you know, we can't command a higher salary because we don't have other - you know, like, there is a belief that you don't have other options but at least, you know, we could insist on certain things, like, we need to get adequate supervision and that was a very hard battle to win and so forth.

But in the period that I was working at that not for profit the NDIS came in and because they could see that the NDIS was going to dry up government grants they just pivoted towards the NDIS and what absolutely sickened and worried me was, again to touch on what the previous presenter said, all of a sudden we were just employing more and more people on a casual basis for $25 an hour to work with the most vulnerable people, the people that had an NDIS plan so they would go out and meet them at their houses and help get them to appointments or whatever.

But, you know, these are people with, you know, fairly entrenched schizophrenia and stuff like that and a lot of people doing the work were studying social work or, you know, might be studying counselling but there was no - am I'm just like, 'Oh, I can't be around this. This is going to be a disaster' because they had no idea that they needed to be getting adequate supervision, they needed to be getting adequate mental health support themselves - you know, the preventative stuff because, you know, if 60 per cent of carers develop mental health issues how many people that actually work in the mental health space go on to develop problems if they don't have the adequate supervision and so forth.

PROF KING: Yes, and taking on from the previous speaker I think we need to make sure we don't end up with the Royal Commission sort of saying 'Look at the abuses in the mental health system because of a lack of trained people'.

MS FITZHARDINGE: Yes, and a lot of those abuses will be towards staff as well. So, I mean, in my email I mention, you know, being in - again working in that not for profit sector we did what was needed and then, you know, you get the government grants and the government - like, we had a federal government grant that said that we had to - that our success would be measured on how many people we saw so we moved from working with the people that needed the support as they needed it to suddenly running workshops (indistinct words) suggest to turn the numbers through just to be able to meet that which was deeply unfulfilling.

PROF KING: Okay.

MS FITZHARDINGE: You know, we were told that we couldn't work with people that had a diagnosis or that were mentally unwell, we were meant to be working with the carers but sometimes you would end up working with someone who was a carer but also had a mental health problem and, you know, would be actively advocating to get them into a crisis situation and sometimes they would get accepted into the State government system, for example, and then their psyches would chop and change, they would cancel - I could not believe how many times people had their appointments just cancelled and rescheduled and good psychotherapeutic support is that you seem somebody regularly at the same time, you know, and you build the relationship and the relationship is one of the tools of healing.

PROF KING: Okay.

MS FITZHARDINGE: Is that enough, sorry.

PROF KING: No, no, that's fine, thank you. Did you have any questions - - -

MS ABRAMSON: No, I was just mindful of the time because we have room constraints.

MS FITZHARDINGE: I know, I know.

PROF KING: We're thrown out of here at five or before five, so.

MS ABRAMSON: So I promise it's not us, it's externally imposed here but we've understood what you've said.

PROF KING: Thank you very much, yes.

MS ABRAMSON: It's been great, thank you.

PROF KING: Thank you.

MS FITZHARDINGE: Yes, thanks.

PROF KING: Hannah McGlade. And if you could state your name, if you're representing an organisation what that organisation is and any introductory remarks you'd like to make.

MS McGLADE: My name is Hannah McGlade. I'm a senior indigenous research fellow at Curtin University. I'm not representing but I'm a committee member of the Medical Board of Australia, I've been a Mental Health Tribunal as a legal member for five years and I'm also involved with the United Nations Permanent Forum for Indigenous People representing indigenous people of the Pacific.

So I have read the fact sheet for indigenous mental health which I fully support the recognition of Aboriginal led services and traditional healing and make the simple point that this is consistent with the United Nations Declaration on the Rights of Indigenous Peoples in particular the right to self-determination and the right to have traditional medicines. We still have quite a long way to go in that regard.

In the last year at Curtin I've been researching Indigenous prisoners disability, psychological disability and their needs and we have grave situation for Aboriginal men, women and children and I looked at prison sites in Western Australia and the issues that were facing the prisoners with psychological stress. Indigenous women, it's not well known, have double the rate of psychological distress than indigenous male prisoners but the levels overall are high.

The prison practices are very traumatic and abusive often and it's self-leading to the creation of disability for Indigenous people who, as you noted in the fact sheet, suffered into generational trauma, racism and discrimination. There were some high profile cases in West Australia concerning Aboriginal women prisoners in the last year and a half. In one case a young Aboriginal woman was transported in a state of psychological distress from the women's maximum security Bandyup. She was transported naked without clothes. She was found delivered to the Graylands psychiatric ward covered in blood and handcuffed and seen by male officers so, you know, she must have been very harmed by that experience.

Another Aboriginal woman was forced to give birth alone in a prison cell even though somebody could have opened the door. We can only imagine what sort of trauma it must have been to this poor lady. Her child was also removed shortly after birth and taken from her.

PROF KING: She was in Bandyup or where?

MS McGLADE: She was in Bandyup.

PROF KING: And they - sorry, I'm interrupting you. I was one of the - I was on ERA WA for a number of years and I was actually acting chair whilst we did the prison report and quite frankly I publicly stated that Bandyup was a disgrace and should be shut so - - -

MS McGLADE: Well, there's a lack of therapeutic approaches for women, there's a lack of Aboriginal healing and therapeutic intervention and considering that the prison is now more than 50 per cent, and it has been for a long time, of Aboriginal women with high needs as a result of their own histories of childhood abuse of family and domestic violence. It's quite shocking.

PROF KING: But women were at one - this is going back a few years so my apologies - women at Bandyup they were allowed to retain their babies in the prison setting I thought for six months or a year or something like that?

MS McGLADE: I'm not expert. The mum and bubs unit is quite small and I'm not sure the particulars of why this baby was immediately removed but we also have the highest level of Aboriginal child removal and infant removal in Australia. In this State increasing levels of infants being removed from the King Edward Memorial have been documented by researchers from Murdoch University (indistinct words) in this last year as well.

MS ABRAMSON: Ms McGlade, this work that you've been doing; is it published yet?

MS McGLADE: I have one publication in the Routledge Journal of disability activism which was just released recently and that's on the prisoner's - prison sites, what's happening there. And I have a forthcoming publication in another book on Indigenous mental health. It's an international publication and I think I've provided a draft of the chapter to you. I haven't got the finalised copy yet. And this publication, the second one, was about traditional healers in the West Australian mental health system. From my five years of experience as a tribunal member I became very concerned about lack of culture safety and indeed discrimination to Aboriginal people and patients and how this could deteriorate their mental health condition.

Notwithstanding that in 2014 the law in WA was changed to ensure cultural safety if possible and ensure the use of traditional healers, community members and Elders but what I saw in this last five years was generally - this law wasn't being recognised or implemented and there was no clear reason why. It seems that the law got changed and then there was no sort of plan around how there would be a commitment to Indigenous healers. So I started a research project with Jocelyn Jones, an Aboriginal epidemiologist, and Sophie Davis who was also involved, chief psychiatrist, and we work with the Wungen Kartup Statewide Aboriginal Mental Health Service who have a lot of responsibility for Aboriginal mental health but unfortunately they don't have the reach to be assisting all Aboriginal involuntary patients and I don't know what level they are but I generally often see people who don't have that support of that service which is a critical service.

MS ABRAMSON: And we're very interested, as you would have seen from our report, in traditional healers and I think we've got an information request in relation to seeking some more information so this is particularly interesting for us.

MS McGLADE: Yes, so generally - so the Wungen Kartup does have traditional healers that they can suggest to their patients but we're seeing from the hospitals generally there's just a lack of, you know, awareness of responsivity to the issues. We interviewed the Aboriginal and non-Aboriginal mental health staff at the service and one of the main themes that came out of the interviews was cultural safety and lack of cultural safety that they were observing to the point where they believed some remote Aboriginal could be misdiagnosed with a mental illness and taken on Royal Flying Doctors to Graylands to wake up and when they went in to go and see what was happening they felt that actually it was not a mental illness, that the person shouldn't have been from their community, sent the person home which was very distressing.

And they told us about themselves; how hard it was to keep themselves safe as Aboriginal mental health workers. They talked about resistance from psychiatrists to traditional healers, they felt like the traditional healers would want to take people off medicines or, 'What has it got to do with healing?' so there was a real lack of knowledge of the role of traditional healing. And this all unfortunately, you know, going against the important principles in the Act and the Chief Psychiatry Guidelines as well. I will provide you with the paper and you can read the - - -

MS ABRAMSON: Yes, we've actually made a recommendation in relation to traditional healers, we've done more than an information request so we'd be very interested in your work.

MS McGLADE: We need a lot of support for the traditional healers, mainly the Ngangkari in Central Australia. They were supported to, you know, become strong as they are and they're actually brought into Perth by the Yorgum Aboriginal Counselling Service who don't have any additional funding to do that but just draw on and we don't think, you know, the traditional healers obviously should be recognised by the mainstream system. They're very - it's a very powerful form of healing. I can say I've actually experienced it myself and very effective as an Aboriginal person. It's a spiritual form of healing and for a lot of Indigenous people the issues of concern are happening on a spiritual level and can often include distress at racism and discrimination which is becoming - people feel a bit more prevalent actually than it should be in recent years.

And I'll just say as well, and I'm happy to have any questions, but we do need a lot of workforce development and we do need support for our traditional healers. We need men and women healers. A lot of women have experienced much higher levels of sexual abuse related to the mission history where this was very widespread against Aboriginal children unfortunately so we need to make sure there's safety for women.

There was recently some charges laid against an Indigenous man who was sexually assaulting women who came to him wanting to know about traditional healing in the south west of the State so we have to very careful that people with integrity and proper standards are being supported. And I'll just say as well that cultural safety is a requirement of medical care. It's a commitment of the Australian Health Practitioner Regulatory Authority, it is in the medical codes of practice and unfortunately though there hasn't been enough consideration by it. I think the colleges and the College of Psychiatry really does need to do a lot of work and I understand from my work with the Medical Board that cultural safety will become law in Australia and there will be a really big challenge as to how the medical profession will be trained to become culturally safe and how it will be implemented and how there will be accountability when standards are not being met.

MS ABRAMSON: Ms McGlade, we'll stay in touch with you because I think your research is particularly - - -

PROF KING: I have one more question though, sorry, yes. One question, and I apologise because this does relate back to the previous inquiry I did as part of the ERA WA. When you were looking at the present system and the treatment of Indigenous people with mental health issues in the prison system and corrections system; were there any facilities, where there any practices that you could say, 'Well, this actually is good, this works' or was it - is it uniformly bad or is there somewhere - you know, West Kimberley, for example, when we were doing the report six years or whenever it is now, West Kimberley were trying a different model. I haven't followed up how that's gone but any thoughts?

MS McGLADE: I didn't look at the Derby Prison which was designed, you know, to be more reflective of the Aboriginal population up there. There was no - I don't think there were any promising practices in West Australia and I studied the reports of the Office of the Independent Prison Inspector, the OICS, and it was quite critical.

Some years ago I was visiting Canada on a fellowship and I attempted to go out to the Aboriginal healing lodges that were being run by Aboriginal people under the Corrections Department there which were very much supportive of healing practices and I did write an article for Indigenous Law Bulletin referring to the Aboriginal healing lodges in Canada but at this point I would say very little Aboriginal culture and healing practices being adopted, there was an Aboriginal women's arts project that was funded minimally that got cancelled from Bandyup Prison, that was a year ago. I met the lady who was funding that out of her own resources actually and they don't seem to have that anymore and I recommended on the prison tour of Bandyup that I went to, that was over a decade ago, that we invest more in that area and it just hadn't happened and it's very wrong.

PROF KING: Thank you, Ms McGlade.

MS McGLADE: Thanks very much.

MS ABRAMSON: Thank you very much.

PROF KING: Thank you very much. Next is Andris Markovs.

MR MARKOVS: Good afternoon.

MS ABRAMSON: Thank you. Would you like us to - - -

PROF KING: Would you like it to be a formal submission?

MR MARKOVS: Yes.

PROF KING: So it will go up on the website and I suspect one of our staff members will grab you afterwards to see if you've got an electronic copy because it makes it much easier.

MR MARKOVS: I sent one through to An.

PROF KING: Excellent. If you could state your name, if you're representing any group what group you're representing and any opening comments you'd like to make.

MR MARKOVS: My name is Andris Markovs. I don't represent an organisation but I consider I represent a reasonable cross section of people with lived experience. As you'll see from my little, I call it my 'Madame Lash discipline sheet' just to keep me on task so I don't ramble, I consider that I'm a fair representative of a lived experience consumer, in my case bipolar. I am the major carer for a family member who unfortunately went through drug induced psychosis with our favourite crystal meth and I also have the double whammy of having comorbidity so as well as the diagnosis of bipolar two years ago, I was diagnosed with throat cancer and that had extra implications for people with multiple diagnoses because I've made my living from my voice for the last 30 years so that brought in a whole lot of new experiences that I've put into my portfolio if you like.

PROF KING: So can I ask - well, can I ask a personal question: are you in remission? Is it - - -
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MR MARKOVS: Yes, we beat the bugger.

PROF KING: Good.

MR MARKOVS: But as with mental health, my experiences, at the time it was like, 'Um, right, we've got you diagnosed. This is a serious illness, just leave it up to us, you're on the clinical train to a cure'. Little did I know, and I should have asked, that the very common side effects of that, and I am still undergoing them, is hearing loss and short term memory loss so as I say very similar to the mental health experience where people often go with the clinical diagnosis and they're basically told, 'Leave it to us, we're the experts' hence one of the dot points I've put on my written submission.

PROF KING: What do - sorry, I haven't read through your written submission fully but what do you think we - where do you think we need to do more? Where should we be concentrating, where are the gaps that we need to fill as we go towards the final report?

MR MARKOVS: Okay. I was very careful to put a couple of opening dot points giving compliments because that's the hardest thing to do sometimes particularly in these sort of inquiry areas. So moving on from the compliments, I think the gaps in the draft report are the systemic. I was looking for some innovative, some creative, some imaginative, some different ways of approaching mental health in Australia rather than the same old same old. So some of the gaps that I saw in the draft are things that we in the sector have known about for many years.

In fact I made the point: there's the degree of restating, and quite well and quite eloquently and well backed up with current data, however if we look back to the 2014 National Mental Health Report there's nothing really new in the draft. There's a few things, you know, I don't want to go too extreme, but, for example, the implementation of the recommendations in that 2014 report haven't sort of been picked up as a criticism in this draft report that you're working on.

I also think another gap is not enough focus on the lived experience consumer and carer angle. We're all aware of the slightly clichéd, but still very true, nothing about us without us and as someone who's sat on various advisory boards and committees including the National Register - I think I've met you, Stephen, and in fact I think we sat when you gave us an update earlier this year. I might be wrong with that but I think so. I've got the excuse of the cancer, lack in memory.

I was looking forward honestly - I was quite pleased with that update which was earlier this year from you - I was looking for something more exciting in here. In fact something that may be more revolutionary, something like, I don't know - I'm just trying to keep it to more concise words. Something like a major change in the way that mental health is approached in Australia. I think I'm not alone when I say that many, many, many people say that we have a broken system and I'm sure you've both heard that lots of times. Now, that's a subject of opinion.

However, to use some objective facts behind that: I find it very disappointing that the majority of our resources in Australia are still directed at hospital and acute care. In spite of the fact, and I don't know if anyone else has mentioned but you're here on the tail of a Statewide WA Mental Health conference and there were many or several people, much more articulate than myself, who spoke about facts like it appears that 90 per cent of the resources in WA, and I don't know how consistent that it is across Australia, go towards hospital and acute care and about 10 per cent go to community mental health services and maybe some other areas that are attached to that.

Now, that's not good enough I don't think as a consumer and someone who works in the area. I would like to see a target of about 50/50 in terms of the effectiveness, cost - you know, cost effectiveness, treatment effectiveness. If we are living in a community or a nation where basically all expenses - all budges have been reduced, cost-effectiveness or value for the buck, bang for the buck, one would think that's something that's really got to be pushed hard and if you look at the financial modelling, as I'm sure you have done, the costs associated with hospital acute care versus community care is outrageous, it's bizarre. I don't know if anyone's mentioned today but the Auditor General in Western Australia went as far as she could without breaking her integrity to make this point as well. So that's another area. I think there's got to be a game changing approach really if we're going to get somewhere.

Another hat I wear is being an old person. I'm 73, I'm not looking for compliments but I know that we've gone forward in my years of being involved with this and I basically go back to childhood. I was born in a refugee camp. I was probably at the outset of my mental health challenges in utero. So trauma is the consistent factor that happens in many people and I'm probably a fairly good lab rat example of that; trauma after trauma after trauma. I don't think that can be effectively treated in a hospital or an acute care setting.

Of course there are exceptions, you know, when there is a psychotic episode of course there's roles for the clinicians but the decision-makers still appear to be clinicians and politicians perhaps and I'd like there to be a realistic round table of if not leading the discussions and the strategic decision-making, at least an equal part for people with lived experience. As I'm sure you would appreciate, I'm not sure about the general public, we're not losers. Some of us are very high achievers. I can give you dozens of examples, you know them. But, you know, there's another cliché. You know, we are experts in our experience just as clinicians are experts in the medical education. I don't know if the statistics - English wasn't my first language hence my name. The most recent statistics from the Royal Australian College of GPs is that by far the majority or the main reason for people making an appointment to go to a GP is mental health and emotional - I think it's 88 per cent of reason - or 88 per cent of people who go to a GP, have a mental health condition may be amongst others. So, you know, it is a serious, serious area.

So, okay, let's leave the clinicians having a significant role but let's enhance the role of people with lived experience, who have been through the mill. I've been locked up in a mental health security ward, I've been sectioned when I was having a psychotic episode; it didn't do any good for me whatsoever. Maybe it did good for people around me, maybe they were protected from me, but my experiences have basically been negative within the system. Let me just get back to some of my dot points perhaps because that's what I said I'd do.

MS ABRAMSON: Can I ask you a question.

MR MARKOVS: Yes.

MS ABRAMSON: You've been very eloquent and I really wanted to understand under dot point 7 where you say, "Not enough focus on how to realistically identify and achieve meaningful person incentive care'. Perhaps you could expand that a bit for us?

PROF KING: Yes.

MR MARKOVS: As bad as my hearing is I was really struggling to hear a couple of people just before me but certainly areas of cultural and ethnic approaches to this should have a higher priority, the obvious one is our Aboriginal population, but I've recently done mental health first aid training, I have the embarrassing title of 'Principal Master Trainer', but with Muslim refugees who literally had blood on their hands three months - well, not on their hands but on their clothes three months ago in Kabul. Their approach to mental health stress I discovered, and I was excited by this, that they actually go to their Imam. Now, lots of don't know that and, 'Why do they go to their Imam rather than their doctor?' So to incorporate all of that, to embrace those many, many approaches to mental health as opposed to just our primary biomedical approach which basically has many times now been debunked for its broken brain damaged chemicals approach. I mean - - -

MS ABRAMSON: So this is about doing - and we've understood this from a number of people who have made submissions to us now - so it's doing more in the community but more in the community actually means - doesn't mean clinical treatment, it's something quite different which is about the ability to lead a productive life and have support to do that?

MR MARKOVS: Yes, and maybe using psychosocial, you know, KPIs and things like that rather than the traditional medical one which is to minimise the frequency and the severity of the patient's symptoms and say, 'Right, that's a success. I've cured you. You are able to sleep now and you've stopped beating your wife'. Now, that's bull to me. That's got nothing to do with it. What has got to do with it is the quality of sustainable life where people can go about what their aspirations may be and be encouraged and if they do have, as they will have - I'm talking about mental health challenged people - as they will have episodes to facilitate something that doesn't necessarily or isn't based around a biomedical model.

MS ABRAMSON: No, we understand and the evidence that we've been given has been very helpful.

PROF KING: So thank you very much for that, that was really good.

MS ABRAMSON: It was very eloquent, thank you.

MR MARKOVS: Thank you, it's also passionate I think.

MS ABRAMSON: I think that's a good thing.

MR MARKOVS: Can I take my water bottle so someone else doesn't get my disease, they might catch a mental health illness. Thank you.

PROF KING: Thank you. So Mr Markovs was the last person that we formally had down for today but as always occurs at the end of these hearings if there's anyone else who would be interested in speaking but hasn't formally put their name down to speak - - -

MS SCOTT-GALE: (Indistinct words).

PROF KING: Yes, please. If you can come up, identify yourself and again if there's an organisation you're representing and then any comments you'd wish to make.

MS SCOTT-GALE: My name is Pamela Scott-Gale. I have two hats. I'm registered as a general nurse and have been for 40 years. I'm also studying my Master's in counselling with a view to go on to my PhD. I'm not going to talk about the counselling from the aspects of rebate and stuff like that. What I do want to talk about is touching on some of the things that have been mentioned today about working in the community.

I'm a grief recovery specialist and there are quite a few of us in Australasia and the research that's come out of America which is from the Grief Recovery Institute and there are studies that were published earlier this year. I don't have them at hand but I could get them to the Committee. And out of America this came from lived experiences - the people who set this up, the two people behind this, John James and Friedman - sorry, his name escapes me - from lived experiences for loss and the grief recovery is not just about grief and bereavement it's about loss and listening to all speakers today what's underlying and is not mentioned in the report is loss and we all have loss in our lives.

Whether it's a loss of a dog or whether it's a loss of a job or whether it's an actual loss of a person or it's a woman that's given up her career to have children, their lost there, someone's been pipped at the post from - going for a job, there are so many losses in life that we just take for granted but it has an impact and when it happens in childhood then the impact can (indistinct words) and a lot of the things that were mentioned about the GP not recognising the symptoms of depression, we know from research that the signs and symptoms of depression are the same as what happens when someone is going through the grieving process so once someone's grieving they go to the doctor, the doctor says, 'Oh, you're depressed', gives them whatever and their on medication and they get onto that medication but they never deal with that loss.

What the Americans have now found from this research is that bringing the grief recovery method and doing a program in the community in groups or as individual through specialists and they're not counsellors, they're specialists who have done this training but it's normally because they want to give back to the community and they want to serve and want to help. It treats post-traumatic stress, it treats depression, it creates anxiety apart from the loss. So to me why isn't something like that being looked at? And I think that that would actually be something that could be used in the community and you can train people - I mean, my research for my PhD I would like to introduce this program into tertiary health care because we have nothing for anyone in health care not just the Ministers, and I've got to start somewhere small because it's, you know, 'How do you eat an elephant?', 'One bit at a time' and I can only start there.

I'm a nurse educator so I'm starting with nurse educators because they're a very powerful group within the hospital I work in and senior nurses and the idea is to I'm having to do a different type of research, and someone talked about research today and how we can use that research, I'm using an IPA method, I'm not an expert in it, I'm going to learn this process as I go along with my research for my Master's which is interpretative phenomenological analysis theory, okay. Please don't ask me to explain all that, it's a bit too complicated and I don't have the time.

MS ABRAMSON: Hopefully it's on the transcript.

MS SCOTT-GALE: But basically it's using semi-structured interviews so it's actually getting the lived experiences of these nurses of their understanding of grief and loss not just in the workplace but in their personal life with a view to gathering their evidence to convince the executive and, you know, the holders within the hospital that make the decision-making, that this will be a good process for me to use for my research with a view to introducing that program and educating staff to do that because I think if we can deal with that in health care in society we can manage a lot more problems because we've got those skills and what this program does is it deals with the issues of grief and loss and that's all I'd like to say.

PROF KING: Okay, thank you very much.

MS ABRAMSON: Thank you very much.

MS SCOTT-GALE: You're welcome.

PROF KING: Thanks.

MS ABRAMSON: Thank you. Is there anyone else?

PROF KING: Is there anyone else who would like to - - -

MS JAMES: (Indistinct words).

PROF KING: Please, come out.

MS ABRAMSON: We only have one constraint which I believe they're going to chuck us out of the room at five o'clock.

MS JAMES: That's okay.

PROF KING: Again if you can state your name - - -

MS JAMES: My name is Rebecca James and I'm sure that you're going to feel battered by the job description but I'm also a registered counsellor.

PROF KING: That's fine.

MS JAMES: And I've just noticed across the day a number of comments that have been made around sort of the counselling body and the application for Medicare rebates and I noticed earlier, Stephen, that when you were saying we're trying to find solutions for the mental health system and you're feeling concerned where we're saying the only solution is to give us a provider number.

PROF KING: Yes.

MS JAMES: I would just like to really invite a shift in what perception has been created for you around that because I think some of the things that I've heard have been the limitations on counsel as to provide the services that we're trained, qualified and highly skilled to provide in a fair, inequitable and recognised way.

PROF KING: Yes.

MS JAMES: So I have a background in psychology and I have my Master's in counselling and I've gone through extensive sort of evaluation processes to become registered. I'm also an associate member of MAPS so I know a lot about what's set up in terms of becoming a registered psychologist and what I'm seeing is that there is a greater parallel, an equity between the capacity of the two professions and yet one of them is being recognised as being government supported to the right of service while the other one is sort of being dismissed by contrast when we have people providing the exact same service with the same measures, the same level of qualifications.

What I don't understand is why we're saying they can all of it but you can't and I imagine it's because in terms of formalising and structuring we've been behind that at an organisational level but we're here now. And the reason I believe that you're hearing about it so much is because our access to address this as an issue to ask for it to be changed and shifted is here now so our voice, in terms of all of the elements of the draft, would be far broader however we don't have the space, the time and the opportunity to demonstrate how broadly we would address different issues. We need to provide a stronger voice now to say, you know, 'Can we address this issue?' because otherwise we're looking at another 10-15 years before it gets looked at again so I just have noticed as I see you, and sort of it's almost felt like there's a, 'Oh, counsellor's asking for money' and I feel like I just wanted to clarify a little bit about that.

PROF KING: Yes, so I understand but it does put us in a difficult position in that - and we will look at counsellors and the potential for them to become Medicare providers - get Medicare provider numbers - but at the same time we're getting a message from counsellors, 'Look, we have so much to offer' but from our perspective we're seeing it as, 'We've got so much to offer but the only way we can go is through this door' which is through the Medicare provider number door and there is no other door which - you know, I have no idea what our final report - where we'll go, what we'll say on that - but if there's only the one door that is being presented us that's the only door we would be able to look at because we need the submissions and the evidence to be able to do the analysis.

So I guess the challenge that I'd put, not just to yourself but to the counselling groups in general is, is that the only door? Is that the only door that you want us to look at and consider because if the counsellors want us to look, and the Counselling Associations want us to look and say, 'Well, actually we could be involved in' - you've talked about different approaches for low intensity treatment. Some other submission have said, 'But we need to train up a new workforce', 'No, you don't, we're here'. Is that another door? But at the moment we're not hearing any of that and we can only respond to the evidence that's given to us and so I get very concerned that the counsellors and highly trained people are so focused on one approach that you're foregoing potentially other doorways to the system and that concerns me because it then limits the ability for us - - -

MS JAMES: I can certainly speak to a couple of aspects about that I believe. One of them is that without that, as was described before, our services are subsequently undervalued - significantly undervalued and this comes at cost to our livelihood so someone doing the same thing able to earn value for what, their worth when we're not is in itself, potentially down the track, a psychologically impacting thing. You're doing the same job but you're worth less and I believe that's not a healthy approach.

The second part is: the reason this feels like the only door in a lot of ways is because without it it's the number of closed doors we face. We do not get access to GPs which is a necessary referrer. We do not have the same access to the broad approach system where you can provide an holistic approach where you're working not just with the mental health issues but the physical issues as well, working with physiotherapists, working with occupational therapists, You've got places like 'Therapy Focus' where they've got psychologists, the OT, the speech pathologist, the physiotherapist, no counsellor because of this door not being open so it's an incredible limitation on our capacity to work in the very area that we're training with this equivalent level of education, experience and measure so I think that is why we're seeing it as an essential door because it's not about we need the Medicare, we need access to the broader system so we can provide that broader service and I believe that broader service is what they're looking at now as being necessary if you're going to see a psychologist and I know brilliant clinical psyches and registered psyches.

If you're going to see them and you're paying them up to $250 an hour and you're $126 out of pocket every time you see them and you're seeing them over ten weeks or weekly, your financial capacity to access a broader health system is then financially limited because you are so out of pocket. What we're looking at is if we were able to be a part of that broader system the price differential is going to be such that the consumers can now afford more services, get a better holistic approach that's actually going to be more effective in treating them and I think that's a really important issue.

MS ABRAMSON: Thank you, thank you very much.

PROF KING: Thank you.

MS JAMES: Thank you.

PROF KING: I will draw to a close here because I think we are meant to be out by five and I notice it's ten to - - -

MS ABRAMSON: An’s nodding at us.

PROF KING: Yes, okay. So I will now adjourn the hearings and they will reconvene next Monday in Sydney.

MS ABRAMSON: And can I thank the Commission staff for their help and assistance today, thank you.

PROF KING: And thank you to everyone who's been here today so thank you very much.

MATTER ADJOURNED UNTIL
MONDAY, 25 NOVEMBER 2019