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PUBLIC HEARING INTO MENTAL HEALTH

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

TRANSCRIPT OF PROCEEDINGS

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

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

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

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

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

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

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

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

participants to ensure that their remarks are not defamatory of any other parties.

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

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

MS ABRAMSON: Who are sitting at the back.

PROF KING: Sorry, at the back there.

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

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

MS ABRAMSON: They're looking at Alistair.

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

MS ABRAMSON: He knows though.

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

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

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

PROF KING: And do you have an opening statement.

MR LOVELOCK: Thank you. I've got an opening statement prepared that I'll read for you now and provide to the Commission. Thank you for the opportunity to discuss the draft report of the Productivity Commission Inquiry into Mental Health. Mental Health Australia

is the peak national, non-government organisation representing and promoting the interests of the Australian mental health sector, and committed to achieving mental health for all Australians.

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

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

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

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

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

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

Today, we'd particularly like to discuss the Commission's three key elements that Mental Health Australia perceives to be missing in the draft report. We believe these components to be critical, and suitable ambitious - for a suitable ambitious reform agenda that will create

once in a generation change in mental health. These are: firstly, articulating an overarching vision for the mental health system, fundamentally focused around recovery.

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

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

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

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

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

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

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

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

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

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

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

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

PROF KING: Yes.

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

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

MR LOVELOCK: Yes.

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

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

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

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

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

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

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

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

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

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

MR LOVELOCK: I mean, I haven't got the answers to it. I know it has been - the general feeling is the principle of regionalisation is one that's well accepted and regarded as a positive

thing to do; that you need regional solutions to deal with service delivery. But it also does provide significant issues for providers in managing, you know, 31 different networks without a mechanism of that being more coordinated.

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

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

MR LOVELOCK: Thank you.

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

MR LOVELOCK: We did.

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

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

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

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

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

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

and a timely way to enable that to inform design principles.

PROF KING: Okay. Julie.

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

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

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

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

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

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

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

MS ABRAMSON: Yes.

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

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

MR LOVELOCK: Correct. That's right.

MS ABRAMSON: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

MR LOVELOCK: Sure. I mean, as you know, the MBS is a problem in that space, because you can only deal with the person in the room, and obviously there would be family issues that would come up as part of, you know, interventions where providers have a difficulty in engaging further, and that's an issue again with the MBS and we probably need to look at

how to make it more flexible to enable some of those more family interventions that are provided, because that's certainly something that we've touched on as well, and we're happy to provide more information.

PROF WHITEFORD: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PROF KING: We recommend navigation portals for service providers.

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

PROF KING: Okay.

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

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

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

MS ABRAMSON: Well, we like that comment.

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

MS ABRAMSON: Thank you.

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

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

MR LOVELOCK: Yes, okay.

MS ABRAMSON: Thank you so much.

MR LOVELOCK: Thank you very much for the time.

MS ABRAMSON: Thank you.

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

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

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

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

MS ARMSTRONG: Yes, we do.

PROF KING: Please.

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

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

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

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

So that's our opening statement. We'd also like to say that we are a signatory to the Charter 2020, and we fully support the Time to Fix Mental Health campaign, and that (indistinct) Mental Health Australia around the launch of that campaign. Our aim is to work

constructively with government to improve policies and programs that directly and indirectly impact the families and carers of people living with mental ill-health. I will hand over to Jeremy, who will raise, I guess, the first issue. We'd like to say that, just initially, broadly we're comfortable with the recommendations made about carer income support and employment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR COGGIN: Can I answer that?

PROF KING: Please, yes.

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

PROF KING: Yes.

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

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

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

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

But obviously, you would ideally co-design the framework with consumers and carers, and service providers, because they are also a customer in that component, and you're providing this constraint about it clearly needs to be workable. And so I think for us, it's a bit like getting a foot in the door. I think where you've been using the care experience survey, I think as an opportunity to get a foot in the door, which is interesting: we recommended a similar

piece for the psychosocial stream and NDIS, because we thought well, if these just captured data, at least people can start going, "Oh, there is a correlation." I note, there are; it makes a difference.

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

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

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

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

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

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

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

PROF KING: Yes.

MS ARMSTRONG: Yes.

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

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

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

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

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

MS ABRAMSON: Yes.

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

MS ABRAMSON: Solution, yes.

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

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

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

MS ABRAMSON: Try and resist.

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

forces that voice in the service design. And we certainly know we need to go through the report to now look at the elements you have, how do we translate them up?

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

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

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

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

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

MS ABRAMSON: Good, understand.

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

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

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

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

MS ARMSTRONG: Thank you.

MR COGGIN: Thank you.

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

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

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

PROF KING: And do you have an opening statement?

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

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

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

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

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

We are very strongly of the belief that services are best planned, co-ordinated and integrated regionally, so we are very positive - and have been, consistently - about the role of primary health networks. And I know you've also canvassed the idea of a regional commissioning authority. I think whether it's a regional commissioning authority or an evolved primary

health network, or a more empowered primary health network, can come out in further discussion. But I think the principle of regional integration, local governance, local clinical and community and consumer leadership, and pooled funding, are the ways we are going to stimulate change, ground-up.

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

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

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

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

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

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

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

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

So I might leave it there.

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

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

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

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

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

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

So to answer your question, I think we need systematic use of patient activation measures; we need systems like community referral and psychosocial referral pathways built into systems

that clinicians already use, to make it easy; and we, ideally, would have, as they do in the UK - and not all roads lead to UK models, there are others - but a network of link workers that can be part of a multi-disciplinary wraparound team, to assist navigate some of those social and psychosocial services, and indeed, referral to other health services as well.

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

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

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

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

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

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

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

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

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

MS GELBART: Yes.

MS ABRAMSON: Yes, I understand, thank you.

MS GELBART: Yes.

PROF KING: Harvey?

PROF WHITEFORD: Leanne?

MS WELLS: Yes, Harvey?

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

MS WELLS: Yes.

MS WELLS: Yes.

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

MS WELLS: Yes.

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

MS WELLS: Yes.

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

MS WELLS: Well, I thin - I mean, I do think it comes, from where we sit and we're not representing and coming from the, you know, consumers with a really acute mental health issue. There'd be other organisations that would speak with much more authority on that issue but on the multimorbidity issue and the fact that, you know, people in that cohort need

specialist mental health services, they need good physical health care and good psychosocial support then it comes back to we do want an integrated system.

PROF WHITEFORD: Yes.

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

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

PROF WHITEFORD: Yes.

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

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

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

PROF WHITEFORD: Yes.

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

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

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

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

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

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

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

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

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

MS WELLS: Yes.

PROF KING: Thank you very much.

MS GELBART: Thank you.

MS WELLS: Thank you.

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

SHORT ADJOURNMENT

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

UNIDENTIFIED SPEAKER: (Indistinct words).

PROF KING: Yes, please.

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

PROF KING: Actually just before we restart let me just reiterate a few things for people who didn't hear this morning. The microphones are just for the transcript. They're not for

amplification. If any media have come in please identify yourself to our staff and given the nature of the proceedings can you please make sure as members of the media you're respectful in your approach. As I said this morning also we know some of you are going to talk from personal experience. please be aware this is public, there will be a public transcript and so please be aware of privacies, protections and refrain from naming specific individuals. We wouldn't want any proceedings out of this that would be undesirable for everyone.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

seen a lot of those models working very well internationally.

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

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

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

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

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

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

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

MS PAGE: Sure.

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

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

MS ABRAMSON: Yes.

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

MS ABRAMSON: Yes.

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

MS ABRAMSON: Yes.

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

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

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

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

more scope then to really upskill around social and emotional wellbeing.

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

MS ABRAMSON: Yes.

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

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

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

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

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

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

MS PAGE: There's some very good integrated models working with highly vulnerable

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

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

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

PROF WHITEFORD: Thank you.

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

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

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

PROF KING: Yes.

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

In the next community down the road that would not be appropriate, right? I think that in the

next community down the road it might be that the neighbourhood house or the local Aboriginal organisation or a group of preschool and kindergarten teachers are the safe places for families or the soft entry points for families, and we would be better building their capacity to be that front entry point that you're talking about.

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

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

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

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

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

For services to do it, they're having to manage - I spoke to one service that's got like 30 different funding agreements, and they're all on different time cycles. Do you know what I mean? So how do you manage your basis outgoings like rent and infrastructure and other things when you don't know whether that position is going to continue beyond the current funding cycle, and that one's coming to an end at the end of the year and the other one - I think we need a funding model for integrated service delivery. We need a lead national - whether it's the Department of finance or - I think it would be the Department of Finance - to

say, 'How can we encourage pooling of funds from different - from education, health and social services in order to fund integrated service delivery on a longer cycle and not rely on individual organisations being so motivated to do it that they're willing to navigate all of those different regulatory frameworks and funding models?'

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

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

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

MS PAGE: Yes.

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

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

MS PAGE: Yes.

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

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

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

By far, the better responses are generally in equipping the adults, whether that's the educators and teachers in the early childhood setting or the parents at home or the broader family, to identify and respond appropriately to the emotional difficulties that a child might be

experiencing. I think we just have to keep putting that message out there and, yes, certainly we're arguing that in the early years it's about laying the foundations for good mental health, as it is in physical health, as it is in every other area, we are preparing children for a lifetime of educational engagement and confidence and wellbeing and relationships.

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

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

PROF WHITEFORD: Right. Thank you, Samantha.

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

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

DR LUXFORD: It's okay, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

family wellbeing overall.

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

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

MS ABRAMSON: Yes. Thanks very much, Stephen.

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

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

DR LUXFORD: In terms of prevention?

MS ABRAMSON: Yes, prevention and early identification.

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

MS ABRAMSON: Yes.

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

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

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

screening program.

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

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

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

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

DR LUXFORD: Yes.

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

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

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

DR LUXFORD: I'll advocate for it.

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

DR LUXFORD: I know.

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

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

PROF KING: Okay. So can I then follow up just on the antenatal care. As we heard this morning, a key element really of optimal service design is co-design with consumers, and in this case with families with new parents, or parents-to-be, and I can see the issue of existing

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

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

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

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

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

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

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

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

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

MS ABRAMSON: Thank you.

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

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

PROF WHITEFORD: Right.

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

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

MS ABRAMSON: It's another gap, Harvey.

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

PROF WHITEFORD: Yes.

PROF KING: All right. All done?

MS ABRAMSON: Yes, thank you.

PROF WHITEFORD: Yes, thank you.

PROF KING: Okay.

PROF WHITEFORD: Thank you very much.

MS ABRAMSON: Thank you very much.

PROF WHITEFORD: Thanks, Dr Luxford.

DR LUXFORD: Thank you very much, thanks.

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

MS RENDELL: Okay, yes.

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

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

PROF KING: Yes, please.

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

trauma throughout life and often it's multiple layers of trauma but that's not usually dealt with.

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

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

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

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

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

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

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

PROF KING: Yes.

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

MS ABRAMSON: Yes.

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

PROF KING: Yes.

MS ABRAMSON: Yes.

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

PROF KING: Yes.

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

MS ABRAMSON: Yes.

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

PROF KING: Yes.

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

know, 'I'm actually okay' and they can go and then develop their creativity so I think those two factors, if we could fix those two factors; the poverty and dealing with the trauma.

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

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

MS ABRAMSON: You can send materials to us.

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

PROF KING: Yes.

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

PROF KING: Signs.

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

PROF KING: Yes.

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

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

MS RENDELL: Thank you for reminding me. Yes, that's the thing, that's what I was just sort of touching on because this particular with the foetal alcohol, he's currently - well, when I was with him, he's no longer with us - but he's still being treated for schizophrenia and he may have as well, I'm not disputing the psychiatrist but that was the focus. Seemed to be a tunnel vision. Once you're diagnosed that's what you are and if I - a couple of times I've

questioned not in a, you know, not in an arrogant way as, 'I don't agree with this', I've just asked, you know, 'Have you considered this, that and the other?', they don't like it. They don't like you questioning. And this boy, he's 12 now, he has monthly injections for schizophrenia, clearly foetal alcohol syndrome.

PROF KING: Yes.

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

PROF KING: Okay.

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

PROF KING: Yes.

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

PROF KING: Yes.

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

PROF KING: Yes.

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

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

MS RENDELL: Yes.

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

MS RENDELL: That's right.

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

MS RENDELL: Yes, very challenging, yes.

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

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

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

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

PROF KING: Yes.

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

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

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

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

PROF KING: Okay.

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

PROF KING: Yes.

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

PROF KING: Yes.

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

PROF KING: I understand.

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

PROF KING: Yes.

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

to the doctor next time we talk to the doctor about this?', you know, so I'm trying always to - and that's what social workers do, empower the client, empower them to be in charge of their health and their recovery because all of them, I haven't had one that hasn't felt like they have agency, they have choice.

PROF KING: Yes.

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

PROF KING: Yes.

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

PROF KING: Yes.

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

PROF KING: Yes, (indistinct words).

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

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

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

PROF KING: Yes.

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

PROF KING: Yes.

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

PROF KING: Yes.

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

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

MS RENDELL: Well, services are wonderful for disability.

MS ABRAMSON: Yes.

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

PROF KING: Yes.

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

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

MS ABRAMSON: Yes.

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

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

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

PROF KING: Yes.

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

PROF KING: Yes, which is - - -

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

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

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

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

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

MS ABRAMSON: Yes. No, thank you.

PROF KING: Thank you.

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

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

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

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

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

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

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

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

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

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

PROF KING: Yes.

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

PROF KING: Yes.

COLIN HALES: Or more in depth, I guess.

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

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

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

PROF KING: Yes.

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

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

MS ABRAMSON: But Commissioners.

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

COLIN HALES: Yes.

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

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

PROF KING: Okay.

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

PROF KING: Yes.

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

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

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

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

MS ABRAMSON: Thank you.

PROF KING: Thank you very much.

COLIN HALES: Thank you for giving me this opportunity.

PROF KING: No, thank you.

COLIN HALES: Thank you.

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

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

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

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

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

MS ABRAMSON: I understand.

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

MS ABRAMSON: I understand.

MS O'BRIEN: Yes.

MS ABRAMSON: Sorry, you go on.

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

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

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

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

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

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

MS ABRAMSON: Yes.

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

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

MS O'BRIEN: Yes.

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

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

MS ABRAMSON: Yes.

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

MS ABRAMSON: Yes, I understand that.

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

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

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

MS ABRAMSON: And just some practical examples.

MS O'BRIEN: Yes.

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

MS O'BRIEN: Yes.

MS ABRAMSON: So that would be really helpful.

PROF KING: Yes.

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

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

MS O'BRIEN: Yes.

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

MS O'BRIEN: Yes.

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

MS O'BRIEN: Yes.

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

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

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

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

PROF KING: Yes.

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

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

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

MS O'BRIEN: Absolutely.

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

MS O'BRIEN: Yes.

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

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

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

PROF KING: Yes.

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

PROF KING: Yes.

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

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

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

PROF KING: Yes.

MS O'BRIEN: So, yes.

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

MS O'BRIEN: Thank you.

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

PROF KING: Thanks.

LUNCHEON ADJOURNMENT

(Telephone link established.)

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

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

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

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

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

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

PROF KING: Yes.'

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

PROF KING: Please, yes.

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

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

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

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

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

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

PROF KING: Yes.

MR McMULLIN: On top of that we really wanted to talk about the - so one of the challenges that came up in the workshop - not the workshop, the discussion online that you guys held a few weeks ago around clear evidence around school programs and there being

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

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

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

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

But I think the overarching thing for us is that a lot of students that leave schools and schools that have really good structures of support and networks around them in general or even just the structures that are there already, what ends up happening is that a student might go to university on-school or take a gap and then go to university after taking a break but there's a real transition at university and I really think the value of the university setting for discussions around mental health I think is really, really great because of that - really, that transition period for the young people or for anyone else who's going to university, not

necessarily young people only, but it can be a real point of transition and points of transition, as has been discussed in this report and other reports around mental health challenges, can be a real instigator of mental health challenges for young people or for other people and I would strongly suggest including looking at universities as gateways mostly because of the real challenges that young people and people in general have in their involvement at universities and I think it could be a good opportunity for us to have those discussions there as well.

PROF KING: Okay.

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

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

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

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

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

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

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

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

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

PROF KING: Okay, thanks for that. Julie?

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

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

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

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

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

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

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

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

MS ABRAMSON: Yes, sure.

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

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

MS ABRAMSON: Great, thanks, Ben.

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

MS ABRAMSON: Thank you.

MR MCMULLIN: Thanks, Julie.

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

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

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

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

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

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

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

MS ABRAMSON: Yes, thanks very much, Ben.

PROF KING: Thanks, Ben, thank you.

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

MS ABRAMSON: Thanks.

PROF KING: Thank you.

MS ABRAMSON: Thanks, Ben.

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

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

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

SHORT ADJOURNMENT

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

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

PROF KING: Yes, please.

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

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

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

MS ABRAMSON: You haven't read 1235 pages?

MS FELTON-TAYLOR: Sorry.

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

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

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

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

The second thing that we wanted to focus on is that the gaps in the services which are identified in all sorts of different reports, including this one, won't be sufficiently addressed without a very strong focus on secondary community-based mental health services. One of the things that we see again and again is a lack of deep understanding of the non-government

mental health service sector; so there is community-based mental health services that are provided by government, but there is also a very important role of the non-government sector, particularly in providing those psychosocial services that help people stay well, integrate into their communities, make a contribution, while they are recovering.

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

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

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

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

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

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

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

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

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

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

So, thank you.

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

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

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

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

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

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

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

MS FELTON-TAYLOR: We also have the other example of working with people who clearly would be eligible for the Disability Support Pension, but won't apply for it because of

the stigma. And I was personally asked to write a letter in support of someone and I found it absolutely abhorrent, what I had to do, because really, I had to write about everything that was not good about this person. And I was told I had to make it as strong as I possibly could, which, given the respect I had for this person, who was clearly intelligent, clearly willing to work but was disabled by their mental illness, I can't put in words how I found having to do something like that.

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

MS FELTON-TAYLOR: No.

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

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

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

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

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

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

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

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

PROF KING: No - - -

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

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

PROF KING: What happens next, yes.

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

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

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

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

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

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

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

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

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

MS ABRAMSON: Go into hospital, yes.

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

MS SARIS: Mind dogs.

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

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

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

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

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

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

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

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

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

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

MS FELTON-TAYLOR: It's both.

MS ABRAMSON: I understand.

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

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

PROF KING: Harvey, do you have any questions?

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

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

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

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

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

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

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

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

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

PROF KING: Yes, okay. Other questions?

PROF WHITEFORD: No, that's fine.

PROF KING: Thank you very much.

MS FELTON-TAYLOR: Thank you.

MS SARIS: Thank you.

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

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

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

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

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

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

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

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

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

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

And in the same year, we made a submission to that, and that report, memorably, used the memorable phrase that co-occurrence of substance dependency and other mental health issues is the expectation rather than the exception. And you have wonderfully included that quote in

the draft report. And at the moment, we're engaged and co-operate with the Canberra Mental Health forum. So that's our engagement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS LEE: No, not totally, no.

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

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

MS ABRAMSON: Yes.

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

MS ABRAMSON: Yes, I understand that.

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

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

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

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

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

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

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

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

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

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

PROF KING: Public housing, yes.

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

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

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

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

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

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

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

much a human face to the sort of thing.

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

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

MS ABRAMSON: That would be great. Thank you.

MR BUSH: - - -links to you.

MS ABRAMSON: And thank you for appearing.

MR BUSH: Yes, okay.

MS LEE: Thank you.

MR BUSH: Thanks.

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

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

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

So the thing is, is that when it comes to, you know, trauma informed care, I think from a policy point of view is that we need - I think it needs to be much more inclusive, and that's all professional roles, need to be much more inclusive across all the policies. So this is from things from, you know, who mental health professionals are to the awards and the rates and pay structures and things like that, employment conditions, because I kind of feel it's a little bit disjointed across them, so in some of those documents there's some professional roles stated, and more the classical ones, but not the other ones. And if we're moving towards a

system where we're going to have lived experience and peer work and things like that everyone needs to be much more included in those documents, and then kind of working down, because from a code of ethics point of view we're all there to improve a quality of life in some form for whatever the person that we're working with. We're there to service the people that we work with.

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

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

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

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

MR DE TOURETTES: Yes.

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

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

PROF KING: On the teachers, yes.

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

MS ABRAMSON: It's not a criticism.

PROF KING: Because we need to be clear ourselves.

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

PROF KING: Yes.

MR DE TOURETTES: So - yes.

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

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

PROF KING: Okay.

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

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

PROF KING: Yes.

MS ABRAMSON: What you mean.

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

PROF KING: Yes.

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

PROF KING: Yes.

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

PROF KING: An alternative?

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

PROF KING: Common.

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

PROF KING: Yes.

MR DE TOURETTES: For example, with the feedback that we've got we'll be looking to

use the - what was it called - the - AMU developed it last year - which has a psycho-social element to it. So it doesn't only ask those, you know, the 10 questions around anxiety and depression, but it also then goes into the psycho-social things, so, you know, "How often have you, you know, had connections with your friends, family?"

PROF KING: Yes.

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

PROF KING: Yes.

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

PROF KING: So it's really - - -

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

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

MR DE TOURETTES: Yes.

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

MR DE TOURETTES: Yes.

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

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

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

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

PROF KING: Yes.

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

PROF KING: Group. Yes.

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

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

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

MS ABRAMSON: Yes that's right.

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

MR DE TOURETTES: Yes.

PROF KING: Yes, okay.

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

MR DE TOURETTES: Yes. Yes, okay. And just as another point, I understand that suicide prevention is a major concern across the world and especially here in Australia and more so here in Canberra. You know, just around the education of that I kind of - coming through the university systems and then, you know, attending other things, other institutions

and courses and whatnot what to do, you know in every health professional that says, we'll engage with suicidal consumers at some point in time. Even though suicide prevention is becoming its own kind of area - - -

MS ABRAMSON: Discipline.

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

PROF KING: Yes.

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

PROF KING: Yes, take it further.

MR DE TOURETTES: - - -the appropriate action.

PROF KING: Yes.

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

PROF KING: No questions there?

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

MS ABRAMSON: Thank you so much.

PROF KING: Thank you very much.

MR DE TOURETTES: No worries.

MS ABRAMSON: Thank you.

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

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

PROF KING: Fantastic.

MR DE LUCA: Thank you.

PROF KING: So just name for the transcript.

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

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

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

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

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

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

University training requirements and quality control of counsellors: many counsellors have

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

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

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

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

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

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

The future of developing a quality workplace and its impact on the counselling profession: as a counsellor I have had to deal with clients who are having difficulty adapting to their work environment which has caused them anxiety and stress. Having post-graduate qualifications

in human recourse management I have become sensitised to the significant issues. As you are aware that a happy work life leads to greater productivity and the opposite is true, so if you're not happy in your workplace you take time off and someone has to do your work which puts more stress on them and you haven't really resolved the issue of what needs to be resolved. For example, Canberra is predominantly a tertiary culture and staff are well-educated, but many people are dissatisfied and maybe that dissatisfaction comes from they're overqualified for the work they do. But I won't really go into what I think about that now, but it can lead to mild depression if you're not happy in your job.

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

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

MS ABRAMSON: Yes.

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

PROF KING: Yes, okay.

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

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

MR DE LUCA: Okay.

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

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

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

MR DE LUCA: Can I interrupt?

PROF KING: Please.

MR DE LUCA: Yes. I think - - -

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

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

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

PROF KING: Like using a mallet to - - -

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

PROF KING: So in a sense they - - -

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

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

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

MR DE LUCA: Your own background, yes.

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

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

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

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

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

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

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

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

MR DE LUCA: Yes, yes.

PROF KING: To a service.

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

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

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

PROF KING: Yes.

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

PROF KING: (Indistinct words) questions?

MS ABRAMSON: Well, the only thing I was going to say is following on from what Stephen said. If you looked at a perfect model and you said, 'Well, we're going to provide

this services in the community', I know we're not there by the way but if were, would you still be of that opinion that, yes, you do need to have psychologists in the school because they do this assessment process et cetera?

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

MS ABRAMSON: What do you mean?

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

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

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

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

PROF KING: Yes.

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

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

So young teachers really do find it difficult dealing with these emotionally complex kids who - and their parents, the parents are 'Not happy with what you've done with my child' and there's one teacher at the moment who's going through a lot of stress over that at the moment because they want to do the right thing and they want to do the right thing by the parents and

the kids in school but they've also demanded a certain standard from the kid and whatever they'd done and it's caused them a lot of stress with all this negative feedback.

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

PROF KING: (Indistinct words).

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

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

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

PROF KING: Yes.

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

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

MR DE LUCA: But thanks very much for this.

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

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

PROF KING: Good for you.

MS ABRAMSON: Thank you.

PROF KING: Thank you.

MR DE LUCA: Thank you.

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

SHORT ADJOURNMENT

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

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

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

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

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

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

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

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

PROF KING: Which is great.

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

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

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

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

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

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

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

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

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

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

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

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

MS CHRISTIE: Sure.

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

You mentioned those social enterprises failed one area that we looked at but we didn't really push very far and we've seen some excellent examples. There's one up in Toowoomba that everyone comments on and I went and visited that particular enterprise. How do you see social enterprises, if that's a doorway into training and then employment for people with

mental ill health, how do you see that scaling up because whilst ones that are visited are great they do seem to depend on individuals who sort of say, 'Hey, I've got a great idea and I've got the time to be able to put this together and I'm just not sure that we have a robust program but depends on having the right people just happening to be there' so your comments on that?

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

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

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

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

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

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

PROF KING: That would be fantastic.

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

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

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

MS ABRAMSON: Thank you.

PROF KING: Yes, thank you.

MS ABRAMSON: Thank you very much.

MS CHRISTIE: Thanks very much.

PROF WHITEFORD: Thanks very much.

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

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

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

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

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

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

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

The second point that I'd like to make is just in regards to some of the reporting on Headspace outcomes. So the report states that Headspace has been evaluated to be only modestly effectively, that was two studies I believe that were cited both from 2015, that data is potentially outdated now but that's not really the key point. What I'd like to address is that

the data sort of heavily relies in the K10 analysis and that there was only an 8 per cent reduction in distress or something like that in one of the graphs for young people in the evaluations that were cited. I'd like you to potentially consider that K10 isn't the best or overarching way of measuring outcomes for young people. There is early evidence to suggest that young people view recovery in a different way to perhaps other ages or other members of the public and I know from myself that that has been very true. I know that when I receive support for my mental health, my K10 and DASS scores for the first couple of years that I received support probably didn't change very much but my life outcomes changed so I had less missed days of work or I was able to get a job first of all, I had less missed days of study, I was able to engage with my studies better and my grades improved but my psychological distress remained on paper relatively the same.

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

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

PROF KING: Yes, please.

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

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

MS ABRAMSON: Yes.

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

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

I guess to me I think part of the thing- and I recognise that the lower intensity options were throughout the report as well, I did read up a fair bit of that because I wasn't quite sure on what was meant by low intensity initially. I think particularly with young people, groups are not popular and they potentially be beneficial but I think a lot of young people might have stress or anxiety or just might not think it sounds very cool to be honest and whether that's, you know, thinking about ways to rethink low intensity options in terms of either how they're marketed or how they're delivered to young people and again consulting young people on that, you know, you could see an increase in young people wanting to take up those options.

I think a lot of people do use online support but they might use it as an interim support to get face-to-face contact. I just know personally that a lot of people I speak to do want that face-to-face contact even if, you know, like potentially low intensity might have evidence that it could be helpful for them, it's also to do with what young people want and what they're going to engage with.

MS ABRAMSON: We're very open minded about this, Fox, so if there are ways that we can get young people to treatment and if you had the time to put in a submission, even a short submission, we're very interested in that and I suppose some of the thinking behind the low intensity was first of the evidence was there but the other thing was we were struggling with trying to get the right services to the right people at the right time and we observed that, you know, with the better access that people were only using a small amount of the session so part of our thinking was, 'Well, how can we get that treatment to people who might need more of that cognitive behaviour therapy?' so that was kind of the thinking that sat behind some of our views on low intensity; (1) it worked and (2) how could we reallocate resources?

FOX FROMHOLTZ: Yes, and it's definitely something to look into. Yes, looking at some of those platforms aren't particularly youth friendly. I know with NewAccess a lot of its done over the phone, a lot of young people are not comfortable over the phone - a large proportion of young people are not comfortable over the phone. Even things like eheadspace where you can talk to somebody over the phone, most people will chat online which can be helpful but again it lacks that - a lot of connection and, you know, kind of as one of those evaluation states that connection with a practitioner is something that's been fundamental to headspace success according to that evaluation.

So whether it's looking at how those lower intensity options can be looked at in terms of how they can be more youth friendly - I mean, the reason things like headspace and ReachOut et cetera were set up for young people was because young people weren't engaging with mental health services because they weren't particularly youth friendly and it's also difficult for young people; to have their voice heard in that arena and even, I mean, you know, even in like a forum like this it's quite difficult for a lot of young people to come to a forum like this and present at a hearing and things like that so that's where that consultation comes key. But I also would stress again kind of looking beyond just things like K10 measures and looking at other outcomes for young people or for everyone in general, particularly young people.

PROF KING: Thank you.

MS ABRAMSON: No, that was terrific, thank you.

FOX FROMHOLTZ: Thank you.

PROF KING: Jane, thank you.

MS JERVIS: Hello. So I'm Jane and I'm just representing myself not anyone else. I'd like to talk about reform area four and 19, mentally healthy workplaces, and D2, workplace bullying. So imagine this: your boss waves a medical certificate back to you. 'It's not detailed enough for me. You need to go and get another one'. She gets a HR rep who says, 'Get the extra certificate and then he'll determine if he wants to get an independent assessment'. She comes to your desk, 'Get me copies of your certificates or I'll notify payroll and get them to dock your pay'. She doesn't sign the certificates, waits until you've left for the day and tells payroll. She picks at random one of your next leave forms and tells you, 'Move this time to this' which isn't correct. Meanwhile your work, it remains ignored, stonewalled and stockpiled by both her and her boss. She gives you tasks unrelated to your

job and lower than your level just before you need to leave the on doctor prescribed half days or it's what she's had for two weeks but allocates right as it's due.

She emails you and when you reply she responds immediately with, 'Communicating with email is ineffective'. Her other emails say, 'Communication needs addressing. You're creating inefficiencies. You don't have any initiative and you're not demonstrating a willingness to meet the capabilities of your level, a willingness'. Another HR rep responding to the formal report you made emails, 'I haven't found anything to indicate bullying. Here's a link to the code of conduct and guidelines and I'll be speaking to your branch head shortly' and those examples are only slices of what happened in that particular experience and it's not your first experience with workplace bullying either not in that organisation.

You finally quit with PTSD. The bully gets higher duties, the HR rep who responded to the report got promoted an award. So this inquiry's about mental health and this is relevant and the effects and tolls of being bullied at work are enormous. You have freeze-fight-flight, uncertainty of what to do, always having to think about how to respond to the bullying tactics being used which distract you from work related to your job which you're still trying to do and you're still trying to progress. It shrivels you inward and you're in a spiral thinking over and over what's happening and what are you going to do, what are your options and what's coming next because there is something coming next, you're just not sure what that is and you're tired and drained and exhausted and you don't want to drag yourself to work but this is your job and I haven't said any about what you are of value to your organisation either.

Tactics used by bullies try to force you into a dance of sorts with them where they'll want a reaction out of you and you will question and you will explain and you will stand up for yourself but they're responding in anger and dominance and using more bullying tactics. You're their target they've locked onto, they're firing and they're going to keep doing that to prevent you doing your work, to put you down, to belittle you and to give you negativity and you're shocked and baffled and annoyed at the injustice of it all.

And then you have thoughts about, 'How can this be any good for the organisation?' and 'This can't happen to anyone else, what can you do, do what you can' but what if I didn't have to deal with this. What did it look like if I had a clear run if this wasn't part of my story, if I didn't have bullying to deal with. Did I choose the right path when my skills and attributes and personality wasted in here? It's compounded if you decide to make a report and then compounded again if you do and then experience how it's handled. Abuse from a bully, because that's what it is, it's abuse, it affects areas of your mind and you're psychologists here so you'll know what that matters but shatters your ability to think straight, clearly and normally. You feel increasingly miserable, you sound different, you look different, you're aware of it and other people are too including the bull though who knows that it's working and that it's affecting you.

Workplace bullying is sick and what was a healthy person from workplace bullying is now sick and you've heard examples from other presenters today about people with mental health needing understanding to get into work and I'm describing examples of if you've been bullied to the extent that you can't cope with that anymore under those circumstances and your last resort is to quit and then you're out of work and you're sick. A recent report seemed to

indicate thousands, more than 14,000, federal public servant respondents in a survey with a high response rate have perceived harassment or bullying in the 12 months prior.

A series of media articles about [workplace name] describes people being mistreated whose job it is to take care of people. 'Do no harm' is an industry motto. Only after the media exposure I think was there an independent review into culture there and what's the whole point of public services? To serve the public. The bullied ones who can't do their job can't serve the public. The ones focused on themselves doing the bullying that probably has a lot to do with power, control and status; how much are they thinking about being of service to the public? Is it any or is it none? Personnel wise, if organisations let higher duties and promotions go to bullies, those with attitude focused on self who are a bit slick and clever with how they're portrayed so that it helps their position and then individuals make calls on behalf of an organisation that are contrary to the law or guidelines or shuffle the problems around, then that organisation's human capital isn't healthy either.

So in terms of the work itself what can't a bully whose been bullied do while they're being bullied and that's their job, you can't function normally under bullying tactics and bullies are blockades. You're giving your value to making your contribution and to helping others and not only is it appalling enough to have to deal with the bully, the abuser, the perpetrator but then to experience what happens if you do make an informal or formal report. In one of the workplaces someone in the executive eventually seemed at a loss and at wits end to the because they can't stop the bullying either so as an aside to you they mention there is the Fair Work Commission. How bad must it have been for that to happen and it's almost as if the executive seems to be letting you know it would be okay if you were to turn the mirror out in order to look back in.

Also imagine though if you've had other situations where a HR rep says over the phone, 'Oh maybe we shouldn't have employed you in the first place. Can you please send me a copy of your resume?' You get a better response when her boss gets involved who says to you towards the end, 'Don't quit before you do'. A safe work employee calls asking, 'Has she ever shouted at you because it's not bullying if you've just been shouted at the once?'. His manager, who you elevate the matter to you, is having trouble getting information out of the workplace so he asks you if you can cough up any names of anyone he can talk to but you don't because you don't want someone who may not wish to be named to be named in an external environment. He emails a copy of his report finding an offence under the Workplace Health and Safety legislation is unable to be proven beyond reasonable doubt, a bit trial like.

Writing on a CEO's behalf and a herd of people equivalent that person says, 'No further correspondence will be entered into, to shut it down'. You can't say certain people don't try everything. Someone who's had the guts to report bullying shouldn't be put under more pressure by having to explain to someone in an oversight role or a review role that they're now not saying something which seems at all to make sense or be appropriate or in line with law either or having what you've raised be minimised, shrugged off or shut down. Deal swiftly and accountably with staff who continued to be out of line after they've been called out. What are individuals in HR up to? What calls are they making and who's aware of them about what they're saying on the organisation's behalf? And people who are in one of those HR line areas, they're not above scrutiny either.

Bullied workers do consider workers comp lawyers no win no pay and going to journalists to tell their stories because of the severity of the impacts of PTSD on their mental health. So my main concern I suppose in looking at the sections that relate to psychological safety at work is around you can still have law or you can still have guidelines but then what happens? How were they followed and what do individuals make a call on? And is it an accurate and a correct call that people elsewhere would be willing to agree with, would the head of the department be willing to agree with that when it is potentially something that could go through workers comp lawyers/journalists.

MS ABRAMSON: Ms Jervis, thank you for putting that on the record. These are difficult things. What would you see in terms of solutions? Like, what would the type of things - because we've thought about this a lot, we've got a section in the report which deals with bullying but what type of reforms would you recommend?

MS JERVIS: I think the main bit is you can have as many pieces of paperwork and everybody knows about that, you have to sign paperwork when you start a job, when you open up your computer screen you've often got to click a button to say 'I agree with all of the code of conduct and how I'm going to treat people'. It's everywhere. All of it is known but when you actually do have instances where someone has been mistreated and bullied at work then if they need to follow what they're supposed to and then they do submit, 'I've been bullied', it's the receptiveness to the people to hear what you've said to look at the evidence and then what do they do with it and then how accountable is that and how transparent is that so I think the gap tends to be often what people in organisations can do and I would say organisations, HR line areas, do play a big role and I have had some HR representatives who have been knowing what has been happening but the examples that I've just given you now about some of the responses of, 'Should we have employed you', 'Send me your resume' or 'I'm backing up the bully, go and get another doctor's certificate and then I'll make a call about an independent review of it or know there's been no bullying' when there clearly has been - - -

MS ABRAMSON: I'll come back to the point. Like, this is a report where we can make recommendations. I know you're talking about workplace culture and that's a really big issue but what practically would make a difference? What could we actually - - -

PROF KING: What could we recommend.

MS ABRAMSON: Yes.

MS JERVIS: So something in there in reform area four where it says there'll be guidelines or making mental health in the workplace just as important as physical injuries, if there's something in there around there needs to be integrity and accountability of people in the system in what they say and do so I think that that is something different to just saying organisations must have a guideline.

MS ABRAMSON: You see, the other thing we've thought about which might not be particular to what you're talking about is workers' compensation so we've really been thinking about a system. What can you do in terms of getting people back to work and making an incentive for an employer to behave in a certain way?', so we've been thinking about that.

We get that it's a broad pictures but we've been thinking about, 'Well, how can you incentivise the system because we observe that people who are away from the workplace with a mental health issue, they're away longer, their return to work is less likely, so we have thought about some of the compensation recognisance. I don't know if you wanted to add - - -

PROF KING: Well, I guess we're still trying to think about where can you get leverage from outside - - -

MS ABRAMSON: To change people's behaviour.

PROF KING: To change people's behaviour or change organisation's' behaviour and one way is using the workers' compensation so saying, 'You should get premium discounts as an organisation if you are putting in place validated mechanisms to stop things like bullying' in which case you literally get a financial award and of course the opposite occurs if there's any bullying and workers' compensation claims due to that so, I mean, I guess it's sort of a crude mechanism but I must confess we didn't know what else to do, what other levers (indistinct words) to do?

MS ABRAMSON: Well, there's one other issue, and I'm indebted to my staff here, transparency around reporting bullying incidents.

PROF KING: Yes.

MS CORMICK: It doesn't go anywhere.

MS ABRAMSON: Sorry?

MS CORMICK: It doesn't go anywhere when people report bullying.

MS ABRAMSON: Yes, we can't - - -

PROF KING: Sorry, yes. But we will actually open up for other people so if you wanted to make that on the record - - -

MS CORMICK: I didn't mean to say it.

PROF KING: No, no, no, please.

MS ABRAMSON: No, it's a - - -

PROF KING: It's perfectly fine, it's just that we can't formally record it that's all.

MS CORMICK: That's fine.

PROF KING: Sorry, yes.

MS ABRAMSON: But the two are linked.

PROF KING: Yes.

MS ABRAMSON: What Stephen's talking about in terms of premiums and reportable incidents of bullying so the two are not unrelated because if you're looking at somebody's premium than an insurer - I know we're getting into technical detail but we're thinking about what they're talking about.

PROF KING: Yes, (indistinct words).

MS ABRAMSON: Yes, so the insurer then becomes aware, 'Well, you know, if there's bullying of one person there's likely to be bullying of other people as well' and it's about patterns of behaviour over time so that's one of the things about transparency of reporting. I mean, I take your point but if it's got a point that somebody actually looks at that data - - -

MS JERVIS: That would raise the question of how does someone who's raised bullying and then there is evidence but then they're told that bullying doesn't exist and bullying hasn't happened? Then what happens there? How is a report handled or how is a report covered up? If there's coverup/denial, then how does that individual feel in terms of being able to even - you know, what is the path for workers' comp? And if they feel like they've been told, 'That did not happen to you. That is not bullying. That is acceptable. We're going to give that person higher duties and oversight of even more people' and the person who told you that bullying did not happen, from HR, is promoted also and given an award?

MS ABRAMSON: Well, what would an outcome look like? As I said we're talking about (indistinct words) because we're thinking about workplace culture. How can we incentivise it? So if you had your choice what would you say would make a difference?

MS JERVIS: I think it is accountability and transparency and integrity of how matters are handled because - - -

MS ABRAMSON: So is that about the internal - I'm a lawyer by training so I'm quite interested in this - so is it about the transparency of the internal processes for resolution of disputes that there would be some oversight elsewhere in a large organisation?

MS JERVIS: In another part of the organisation?

MS ABRAMSON: Yes.

PROF KING: Well, to avoid - you know, let's say - I'll pick on the public servants - but let's say there is a culture in a particular department or part of a department where even though formally there's meant to be transference, if there isn't where bullying claims aren't taken appropriately, should there be in a sense somewhere else that the person can say, 'Look, what's happening here in this department isn't right. It's not transparent, it's not an open process'?

MS JERVIS: I think the executive, if you've raised it with them then they know what's going on but, you know, I think HR, if that is where normally people go to, then perhaps

there's scope there for HR representatives where there have been cases of bullying need to be perhaps trained and understand what bullying is, what is their response supposed to be - - -

MS ABRAMSON: You see, a lot of organisations, and I'm not talking about a particular organisation, but these are risk events that need to be reported so they're actually reported to a particular committee that there's X number of incidents this month so, I mean, I get your point about if the people who are dealing with it don't regard it as a bullying incident but overtime you can a number of incidents which are reported to risk committees usually so that's why I was just asking you about mechanisms around that because you said, very helpfully, 'Well, it's about transparency and accountability' but in the corporate world we tend the build that by a reporting mechanism through to particular committees who have that responsibility. It sounds like a very bureaucratic thing but it's about risk management to be honest. So it's about who has have line of sight of what you're talking about at a senior level.

MS JERVIS: So, yes, HR would as would executives and - - -

MS ABRAMSON: But HR reports somewhere which is my point.

PROF KING: Yes.

MS ABRAMSON: So it's not just a matter of what's in their bailiwick but they have to report incidents especially of somebody's off on compensation payments then it has to be reported somewhere.

PROF KING: So would it be to the order of a risk committee (indistinct words)?

MS ABRAMSON: Yes, that's right. We're just thinking aloud about your accountability point and transparency.

MS JERVIS: Yes, so I don't think that there wouldn't be reports but it does come down to the handling of it and if there are instances where it hasn't been handled well then I suppose you two don't know - does that then become, 'This is the standard we accept' and that then becomes, 'This is how we handle cases' and 'Once before I've followed a process to find bullying did not exist so next time I get a case bullying did not exist?'

PROF KING: Yes, so the individual case that you've obviously gone through, it's almost like it was your word against somebody else's word. You said, 'This is what happened to me'. They said 'Nothing happened to you. That's an over simplification' and at a macro level if that's the culture there should be more people like you who are getting that same outcome that it didn't exist and more people saying, 'Well, it did'. If that could be collected and that place is identified as a work environment where there's lots of psychological injuries occurring, could it be handled the same the way that it was a workplace where there was a lot of physical injuries occurring and some action had to be taken to make that a safe workplace? So it's almost impossible for us to deal with an individual case in an individual workplace but if the culture's there that lets continue what you went through, then somehow we have to be able to shine a light on that - - -

PROF WHITEFORD: There should be pattern of (indistinct words) macro level or institution level (indistinct words).

PROF KING: And take action.

MS ABRAMSON: That's right.

MS JERVIS: Otherwise it goes on and on.

PROF KING: Yes. I mean, that does not in any way diminish what you've said.

PROF KING: No.

MS JERVIS: You've been very courageous to come and talk to us but it's about the usual observation is, as Harvey said, there are patterns of behaviour and they're observed over time. It's not just one incident, it's a number of incidents that build up that we need to think a bit about.

PROF KING: Yes.

MS JERVIS: Or in one of the other examples there was someone who was known to have been bullying and it wasn't fixed until that person retired just with them retiring, so.

PROF KING: Yes, so - - -

PROF WHITEFORD: Which is unsatisfactory.

MS JERVIS: Yes.

PROF KING: And so the pattern was hidden.

MS JERVIS: Yes.

PROF WHITEFORD: So that person's bullying continued and for some reason that environment protected that bullying person or hid the outcomes on the people who were bullied and I guess that's the most toxic place you can get and so trying to pull that open and shine some light in there and identify that so it's not hidden and ongoing, is what we're trying to think about, a mechanism to do that as would occur if you were breaking a bone every time, then somehow that would be collected, there's multiple broken bones from a certain machine or whatever that doesn't work and that's transparent, - - -

PROF KING: That's then reported and - - -

PROF WHITEFORD: Yes.

PROF KING: And so even if the workplace says, 'No, the injury wasn't due to the workplace', well, it's still an incident that has to be reported and logged and as that

information gets gathered up it becomes a body of evidence or, 'Yes, it is the workplace that's at fault here' even though the workplace may be claiming otherwise.

MS JERVIS: And with procedural fairness there is not a lot that can really be told to the person that reports so even if sanctions were applied I won't know that. If sanctions were applied, did they work?

PROF KING: Yes.

MS JERVIS: Did they have enough sanctions available?

PROF KING: And that leaves the individual in a very unsatisfactory position.

MS JERVIS: Yes, if the end result is that you quit as a last resort because it's too bad and you've tried everything that you can but you still mourn not having been able to stay in there and what if you had had a clear run?

PROF KING: Yes. Thank you very much for coming in (indistinct words). We don't have any solutions at the moment but we'll work on it.

MS JERVIS: Thank you.

PROF KING: Thank you. I'm not sure how many of you were here earlier on but normally we allow a bit of time at the end for people who, if they'd like to, haven't registered officially to make a submission but would like to do so and I'll look to you first because you did want to make a comment. Would you like to formally make a comment on the record?

MS CORMICK: Well, yes, I don't care if I'm in regional - - -

PROF KING: Yes, so please come up. So you're happy to state your name and - - -

MS CORMICK: Oh dear, okay. I haven't prepared anything.

PROF KING: No, no, no.

MS ABRAMSON: You don't have to, there's no obligation.

MS CORMICK: My name is Mary, Mary Cormick. I'm a public servant. You know, I know what Jane's been through but it's not only Jane, I know several people that have been bullied in the public service and they're bullied by managers who appear to be very professional and nobody seems to be aware that they're a bully, certainly not their superiors. I think the bully down but they act differently up.

PROF KING: Right, yes.

MS CORMICK: I don't know, it just seems to a bit prevalent and the people that I know that have been bullied they suffer post-traumatic stress disorder. It's really serious, you know, and it's ignored.

PROF KING: Yes.

MS ABRAMSON: Well, if you had - what would you do differently? What would make a difference in terms of recommendations?

MS CORMICK: I'd have psychologists on the panel for everyone that's going to join the public service and, you know, if they're going to get promised I don't know - look, it's a really hard problem. Psychopaths can pass psychology tests I know but I don't know, I've thought about it and I don't know - okay, like, what Jane said, HR areas don't do anything about it. Something's got to change in HR areas of departments - I don't know what, it's just a very hard problem.

But, you know, the workers' comp that's going out for workplace bullying is really going through the roof. People are, you know, having to pay money for this and that's what's going to make a difference, when money goes out the door money talks and that's when things will start changing. People don't know what else to do so they're going to the no win no pays, they don't have a job, they've had to leave their job, because of the bullying they're out of work.

MS ABRAMSON: Well, we have thought a bit about mental health literacy, for want of a better word, so would you see a role in HR for people to have further training in understanding mental health issues?

MS CORMICK: Absolutely but, you know, people can move around in public service departments, they don't have training in anything, they've just got to do an expression of interest internally and go to a different area in the department. You know, people aren't trained for the areas they're in most of the time and if somebody is in there that's trained they move on to another area and someone else comes in and fills their place so there needs to be a protocol that's really adhered to somehow, I don't know.

PROF WHITEFORD: Can I ask you a question. So the example you gave where WorkCover claims are going through the roof - - -

MS CORMICK: They are.

PROF WHITEFORD: Say if I was the chief executive of a company or a department and I was having my - the amount of premium I had to pay going up and up and up and up because I'm having repeat injury to my workers and I'm accountable for that payment. I've got to find the money to pay those increased premiums, we would have thought perhaps that that would shine a light for the chief executive equivalent that I've got a problem as it would in a workplace which was toxic because of air pollution or toxic because the machine is injuring my workers on a production line or something - - -

MS CORMICK: Yes, so you don't have safety railings somewhere or something.

PROF WHITEFORD: Exactly, so if we could try and say that a psychological injury is as bad, and some often worse - in fact from what the figures are of the physical injury, then we need to get that out into the open so that we respond to it the same way we would as a 'physically' unsafe workplace.

MS CORMICK: Yes. I mean, it's obvious a physical injury there's blood, there's broken bones, but a psychological injury through workplace bullying leaves people with PTSD and people can't see that but it's there.

PROF WHITEFORD: But the WorkCover claim investigation process or the Comcare claim is to find out whether there's an injury. Injury is a diagnosis so a diagnosis of PTSD is an injury so equivalent if it occurs in the workplace so that legislatively should be treated the same as, 'This person's broken a bone in the workplace'.

MS CORMICK: Absolutely.

PROF WHITEFORD: 'They have the injury'. And workplaces that are unsafe from that point of view should be responded to in the same way as I would see a place where everybody's getting asbestosis or something.

MS CORMICK: Yes, so why isn't it like that?

PROF WHITEFORD: Well, I guess that's our question, that's where we're going.

MS ABRAMSON: That's right but we have some recommendations around this where we've - even though the mental health of the workplace is actually encompassed in the work health and safety duties what we've said it needs to be elevated so that you can see that it's on equal footing with physical injury.

MS CORMICK: Yes.

MS ABRAMSON: So we've thought about - it sounds a bit abstract but we've thought about the legislative levers and as I said we've talked about compensation because we're thinking about how can we actually change behaviour and those are the things we've been thinking about.

MS CORMICK: Which is the hardest thing in the world but money talks and when there's money going out the door that changes behaviour.

PROF WHITEFORD: Yes.

PROF KING: That's why we're thinking about workers compensation (indistinct words) - - -

MS CORMICK: Yes, yes.

PROF KING: As being the lever there.

MS CORMICK: It would be great if you make some sort of recommendation that really makes a change in this area because it's really needed.

PROF KING: Okay.

MS CORMICK: I have a friend who five years ago was bullied and whenever I talk about it or she does she bursts into tears. She's very competent and she's manager level, you know, it's just terrible to see it.

MS ABRAMSON: Well, thank you.

PROF WHITEFORD: Thanks very much for taking the time.

MS CORMICK: Thank you, sorry.

MS ABRAMSON: For your impromptu appearance.

MS CORMICK: I didn't mean to butt in.

PROF KING: No, no, that was very good, thank you.

MS CORMICK: Okay, thank you.

PROF KING: Would anyone else like to make a statement, make comments?

UNKNOWN SPEAKER: I guess I'll just add to my - - -

PROF KING: You'll have to formally come up here to add - sorry, it's just that it has to be on the transcript.

PROF WHITEFORD: Someone's put up their hand behind you.

PROF KING: Sorry, yes. Yes, please.

UNKNOWN SPEAKER: Yes, David would like to.

PROF KING: Again if you could just state your name and if you're from a particular organisation representing them state that otherwise - yes.

MR LOVEGROVE: Hello. Look, thanks very much for the unexpected opportunity to be able to say a few words. I came here mainly to be an observer but it's great to have a chance to, even in a more conversational dialogue say, so I have an unprepared sort of few words.

PROF KING: But first your name just for the transcript.

MR LOVEGROVE: Yes, David Lovegrove is my name. I'm a health and wellbeing advocate of the last 16 or more years and a mental health advocate by lived experience for the

same period and I've also previously worked in the public service - Australian public service - as well as training and practicing as a stretch therapist or stretch teacher over a number of years as well just to get that physical balance to mental health work. But, you know, I don't represent any organisation here today. I'm here as an individual and just observing the good work that the Commission's trying to do in terms of furthering the cause of reform in the national and local mental health systems as they are.

So, look, I was just wanting to really pick up something that was touched on a couple of times and I acknowledge some of my other colleagues who are speaking out of lived experience as well but just on the question of how do we value lived experience best in the systems and where would we focus our attentions?' and I think one of the big problems I've had over the years is there seems to be a cultural and systemic resistance to actually investing in structures that actually foster the lived experience voices perhaps beyond - perhaps calling on people to give their personal stories so I've been working mainly in systemic advocacy over those 16 years so lifting the lived experience stories into those voices who can't otherwise sit on committees or decision making bodies to actually get the lessons of those stories into those arenas and I think there's been - it just strikes me, there's lots of calls for the need for having the consumer focus system and to have, you know, people with lived experience involved in policy and in a whole lot of different areas but no one really wants to invest in structures that actually foster that and I think that's a huge issue across the whole country as well as at the local and grass roots levels.

So, I mean, we're lucky (indistinct words) in a sense we've got a consumer network, ACT Mental Health Consumer Network, we've got - now we've got a lived experienced consumer mental health research body at the ANU which is great so we've got some building blocks. We're starting a recovery college that's co-run by people with lived experience so slowly we've got to start building these building blocks but I think in terms of feeding into the rest of the system and within and beyond the mental health sector, there's a lack of really wanting to get that collective voice established and in structural or systemic ways and I think that's a real problem, whether it's even developing peer workers, peer work services, often we're just tacked on the end of - at the bottom end as it were of already, you know, very hierarchical class sort of driven system of authority and priority in terms of peer worker service and it's a really dilemma for people with lived experience who do bring a lot of other talents than their lived experience of mental illness on mental issues and that could really bring a lot of value to a whole ranges, like previous colleagues mentioned, a valuation but I think that's not the only one.

Perhaps that's a false question to ask, 'Which part of the system would we employ lived experience if we had that choice or if we only could pick one?'. Well, I think perhaps that's a false way of putting it because I think people come to the system with a whole lot of abilities and skills but if they're working through lived experience that takes a whole new dimension and a lens for which to approach the way that people can be helped and to recover for themselves as well as for those that the systems are there purportedly to be wanting to, you know, help recovery and to be productive and, you know - well, members of society so - yes.

PROF KING: Can I ask a question on that. So in some ways, you know, there's the formal peer workers, people lived with experience being formally involved, there are many people with lived experience of mental ill health who will be reluctant for a variety reasons but

including stigma to identify - to take on the role of saying, 'Well, yes I've been there. I can offer support' because it affects the perception of themselves. Can you see any way that we can help or reduce these stigmas as being partly a barrier to broader engagement of people with lived experience in the community and, if so, do you have any thoughts about how we might address that or (indistinct words)?

MR LOVEGROVE: Yes, look, I think it does definitely, stigma, and discrimination are huge barriers and often where you wouldn't expect it most within the mental health sector itself and within services that are there to in some ways help people but that's all the more reason why I think we need identified structures and institutions that help that are there to bring out those with identified lived experience who are wanting to not be totally identified as that's their whole identity in life but see their work through the very process of using their lived experience to help make it better for other people who experience similar things and to bring lessons to the wider community and society about how they can do things better in terms of making life and supports for people more effective, more win/win for everyone in the community and society so I think that just reinforces the fact we need this set of building blocks and investment in people but investment in their collective voices and their collective ability to share, you know, so.

And what struck me and got me into this consumer advocacy work is that a session of people with a whole lot of different diagnoses coming together, a lot of different experiences in the system, but regardless of the diagnoses how much in common people had in terms of their experiences with access or some aspect of the service system that wasn't actually treating them in a human or a personal-centred way so I think that's the power of peer and lived experience workers right through the system is critical for showing how things can be done in different way, you know, in a way that's win/win for everybody and a lot less costly for the system as a whole if people have to, as it were, fall off the cliff before they can get the help they need.

PROF KING: Yes, I think the - I guess the parallel I'm seeing with physical health within a workplace, within a social environment, and so on it's quite common to sort of say, 'Oh, yes this person had this particular (indistinct words) open about it all', 'Yes, well, my doctor I might need that so' and then you have an open chat as well. That's a dialogue that just doesn't occur in general for mental illness.

MR LOVEGROVE: Yes, because it takes so many forms in terms of its impact I suppose. It just can't be - - -

PROF KING: But it also seems to be due to the stigma associated with, so.

MR LOVEGROVE: Yes, sure, sure. And understandably if you can avoid having to - because it's seen still as a huge weakness, there's something wrong with you, and I think that's part of the problem that the system still tends to generate. It's focusing on the problem of the person or they're the problem rather than perhaps the ways that a cookie cutter system tries to fit everyone within the same moulding like you might treat someone with - well, you don't even do that with someone with a broken leg but perhaps in much more differentiated ways that are needed to be highlighted that otherwise wouldn't be if there wasn't people with lived experience there to be supported, to be informed these systems will (indistinct).

PROF WHITEFORD: So any thoughts on what recommendations we need to make?

MR LOVEGROVE: Well, I think there should be - well, I think, you know, a whole range of peer work structures need to be supported and perhaps one I know, especially in regional areas, that brings people together with peer workers so they've got the common peer workforce support structure or that goes to things like training, mentoring, peer supervision, professional development, so that we can get a standards that everyone can also contribute to and then also get external independent support from that then through their own choices and abilities then choose to where they want to them fit within the service system so if they had an independent sort of body that they could have that support with, and there's plenty of international evidence on the power of peer support and peer advocacy and peer work in terms of really adding to the recovery and many social values and goods for other people that they can help just by being within various ways, I think would be hugely beneficial. You know, people are calling out for, 'We need to be able to do co-design and co-production' but without the structures in place to actually bring that about then people are just going to be one off cherry-picked and they won't get that critical mass to be a transforming cultural change agent that I think peer workers can be.

PROF WHITEFORD: That's great.

MS ABRAMSON: Thank you.

PROF KING: Thanks, David, thank you.

MS ABRAMSON: I think we're up to an end Stephen.

MS CHRISTIE: Thank you.

PROF KING: I'll just need you again to say your name for the transcript.

MS CHRISTIE: Yes, Julianne Christie. I just had something to add to the other conversation about the workplace and the ongoing bullying situation. One of the barriers to actually discovery these sorts of things are government entities that are self-insured.

PROF KING: Yes.

MS CHRISTIE: It is not in their interest to disclose those sorts of ongoing workplace injuries and on top of that in New South Wales, that is my experience, that people are very familiar with WorkCover as the body for physical injuries. They're not very familiar that WorkCover can also deal with mental injuries and so I think an awareness campaign around those issues of WorkCover covers physical and mental injuries would be most beneficial. But the self-insured issue where the organisation has no reason to disclose and every reason for the HR department to bury it, I think are a reporting role of doctors perhaps when they're making that diagnosis of PTSD or serious mental ill health would go away to taking away that organisation's ability to hide what's really going on. There are already mandatory reporting requirements of these health professionals and so it's probably not much of an extra ask in that in respect.

The other thing that I wanted to add was that in a two minute internet search I actually went to Scandinavia first for examples of social enterprises. They have an excellent definition of 'a social enterprise' compared to Australia. To Australia a social enterprise is basically an organisation that conducts business but it also has a social mission, whatever that may be. Sweden's definition, they actually have a work integration social enterprise, the acronym is 'WISE'. They were defined through a project that was funded under the equal program which was part of the Swedish government and they have some form of economic activity producing, selling goods and/or services. They have a primary objective of integrating people that have significant difficulties to obtain and/or keep a job in work and society which is very different to the Australian definition. They create participation for worker's ownership, contractual and other well documented means. They reinvest most of any surplus in their own activities and draw up similar activities which is what happens how, they're generally not profit - - -

MS ABRAMSON: Julianne, could I just ask one thing of you mindful of the time. The social enterprise is actually a big topic so I would really welcome if you wanted to put in a submission and to talk to us further about that because I'm just a bit hesitant to have the full conversation now because it's a big conversation and I know some of our staff actually have some questions about that so I would invite you to put a submission in and a staff member who has an interest in this might have another chat with you about it.

MS CHRISTIE: Okay, no problem.

MS ABRAMSON: Thank you.

MS CHRISTIE: The other thing that I thought of when I'd left the pressure spot, Spotless Cleaning Services is one social enterprise in Australia that is already operating on the scale.

PROF KING: Yes, that's true.

MS CHRISTIE: Thank you.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Thank you.

PROF KING: Please - - -

MS ABRAMSON: No, we should close it, Stephen.

PROF KING: Yes, you will have to be very quick because we're meant to be out of here by five.

MS LIPSCOMBE: Okay.

PROF KING: And again if you could state your name again.

MS LIPSCOMBE: Sure. My name is Joan Lipscombe. I'm a member of the (Indistinct) mental health forum but I'm not speaking on their behalf because we haven't had an opportunity to discuss your report. Now, before I comment on the report, in relation to the workplace injury and so on many (indistinct words) public servant and if we had problems we went to the union so whatever happened to them? My comments on your report are related - we did put in a submission so they are related to our submission. The submission focused mainly on physical health and the very poor statistics on the physical health of people with serious mental illness, I notice that you've got in your report the figures showing that the cost to the country, if you like, of treatment, education, housing and so on is around \$43b-\$53b every year.

The cost of diminished wellbeing, \$130b a year of which, and I think I'm correct in saying, the substantial proportion of that is due to early premature mortality due to preventable (indistinct words). I've only looked briefly through your summary, I haven't had a chance yet to look at either of the volumes but I found comments and recommendations relating to the physical health of this group to be hard to find. Maybe I missed them but they didn't seem to prominent. (Indistinct words) the huge cost on the human, you know, personal costs. We were recently informed that the mortality rates for this group of people are worse than four indigenous people.

Now, I don't know if it's true but I was assured that by the current head of the ACT Office of Mental Health and Welfare so I think should would probably have an accurate knowledge of that information. So we did make some recommendations relating to physical health and I don't have - well, I do have them with me but I won't read them out because I refer you to them. In particular there are two which you more or less adopted but you only applied to mental health commissions and we believe, well I personally believe, that should be extended to mental health professionals in general not just mental health.

One of them related to stigma and discrimination and the other related to the funding of innovative services and new models for mental health care. We ask for physical health care with people with mental illness and integrated services where people are considered as people as a whole and not mental health here, physical health (indistinct words) so those were two that we put which I (indistinct words) look at that again in order to put a bit more emphasis on physical health care.

PROF KING: Thank you.

MS LIPSCOMBE: I've finished.

MS ABRAMSON: Thanks.

PROF WHITEFORD: Thanks.

PROF KING: And I will have to wind it up there because it's five o'clock. So thank you very much for your attendance. Let me just see, I think I have something here that I say at the end. Yes, I adjourn these proceedings and the Commissioner will resume hearings in Melbourne on 18 and 19 November so thank you very much for your attendance today.

MS ABRAMSON: Thank you.

**MATTER ADJOURNED UNTIL
MONDAY 18 NOVEMBER 2019**



Australian Government

Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

PROF STEPHEN KING, COMMISSIONER

MS JULIE ABRAMSON, COMMISSIONER

PROF HARVEY WHITEFORD, ASSOCIATE COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

**AT LEVEL 12, 530 COLLINS STREET, MELBOURNE
ON MONDAY 18 NOVEMBER 2019**

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PROF KING: Welcome to the public hearings following the release of our report for the Productivity Commission's inquiry into improving mental health in Australia. My name is Stephen King and I'm presiding Commissioner on this inquiry. My fellow Commissioners are Julie Abramson and Harvey Whiteford. Before beginning today's proceedings I would like to acknowledge the Wurundjeri people who are the traditional custodians of the land on which we meet today, and pay my respects to the Elders of the Kulin nation, past, present and emerging. I extend this respect to all Aboriginal and Torres Strait Islander people in attendance today.

The purpose of this round of hearings is to facilitate public scrutiny of the Commission's work and to receive comments and feedback on the draft report.

This hearing in Melbourne is one of many around Australia, in all the states and territories, both capital cities and regional areas. We will then be working towards completing a final report to the government in May, having considered all the evidence presented at the hearings in submissions as well as other informal discussions. Submissions and comments to the inquiry will close on 23 January next year.

Participants and those who have registered their interest in the inquiry will automatically be advised of the final report release by government, which may be up to 25 parliamentary sitting days after completion. We like to conduct all hearings in a reasonably informal manner but I would like to remind participants that there are clear structures in our legislation for how these hearings are legally backed and a full transcript is being taken. For this reason comments from the floor cannot be taken.

The microphones that you'll see at the tables are purely for the transcript. They are not for amplification so I would ask people if they were able to speak up when providing evidence and we will try to speak up when asking questions.

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. These proceedings will be live streamed to the Commission's YouTube site. All participants who have registered to be here at this hearing confirm their understanding that they may be visible or audible online. If anyone here has queries about this or does not wish to be visible or audible online please approach one of our inquiry team members here today or feel free to leave the hearing now. Just inquiry members at the back, just pop up your hands so if people need to note you and I think Ken and Matt are outside as well.

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 that their remarks are not defamatory to other parties. Some people today will be talking from personal experience but I would ask them to refrain from naming specific individuals just to avoid the issues of both privacy or potential defamation.

You are all free to enter and exit the room as you want. If anyone needs a quiet space, please feel free to exit the hearing and use the visitor's room next to the disabled toilets. If at any time you feel distressed please approach one of our staff who will assist you. We also have with us Bronwyn Williams who is available to provide psychological support and Bronwyn is

just at the back there.

In the unlikely event of an emergency requiring evacuation of this building, the exits are located directly in the hallway between here and the lifts. Upon hearing the evacuation tone please leave the building and assemble at the grassed area across at Bligh Street.

MS ABRAMSON: It's at the back.

PROF KING: At the back, good, I'm glad someone knows where Bligh Street is. Unless given an alternative assembly location by the fire wardens. Your assembly point is Enterprise Park which I think is the one down near the Yarra. If you require assistance please speak to one of our inquiry team members here today. If there any members of the press please let yourselves be known and by our staff and - well, members of the press are more than welcome. Again, if they could behave in a manner fitting of this inquiry. I would ask people to put their mobile phones on silent before we start.

Now, our first participants today are Dr Ben Goodfellow and Associate Professor Campbell Paul and I invite them to identify themselves for the purpose of the record. Please come down here and if you can state your name and affiliation and if you're representing a party who you're representing and so on.

DR GOODFELLOW: Of course. Good morning, I'm Ben Goodfellow, an infant child and adolescent psychiatrist and psychoanalyst.

ASSOC PROF PAUL: And I'm Campbell Paul. I'm an infant psychiatrist and I'm representing the Australian Association for Infant Mental Health and the World Association for Infant Mental Health.

PROF KING: Fantastic. And do you have any opening statements or remarks you'd like to make?

DR GOODFELLOW: Yes, we do, thank you. So firstly, thanks indeed for such an excellent opportunity. The Royal Commission very much underway in Victoria and now the Productivity Commission across the nation. I think there is a place for cautious optimism that will reform and changes will be possible to this system that needs it so much. Professor Paul will introduce himself further shortly.

Briefly I'll just say a little more about the areas and places that I work. As mentioned I'm an infant child and general psychiatrist and psychoanalyst. I've been a consultant and child psychiatrist at Geelong CAMHS for eight years. There my roles are as the lead for the perinatal and infant mental health service, the paediatric consultation liaison which is psychiatry within the paediatric setting from the (indistinct words) outpatients. I have quite a lot to do with child protection and also general supervision and clinical leadership for the team shared with two other psychiatrists down there.

I have a private family and (indistinct) practice here in Melbourne seeing infants, young children, teenagers and adults. I'm several years into my training as analyst with Freudian School of Melbourne. I've also been on the board of Alfred Health for five and a half years

and I'm chair of the Primary Care & Population Health Advisory Committee there and for what it's worth I also have two family members with a major mental illness.

So my comments today, and in the written submissions that I'll put forward before the end of January, are informed by these perspectives but it's important that I underline that I'm here as an individual and not representing the views of any of the groups that I work with. I think the - I was very encouraged to read the draft report, the fact that it examines not only the clinical domains but also many systemic and structural reforms that are necessary and of course the funding stems, it's very encouraging that the scope of the form is so broad.

Where I think there is an under emphasis and therefore a significant opportunity for us to put some views forward is with respect to the changes that might be helpful in mental health for very young people. The report quite explicitly in part 4 is interesting in prevention and early intervention and self-evidently prevention and early intervention couldn't start any earlier than in the perinatal period and in infancy and early childhood. . These are areas of mental health and physical health that are not as well understood in the community more broadly and within medicine and paediatrics as they could be.

Some key points that I would hope to advocate just to state them as sort of headlines terms, it would be excellent if we could move towards parity with paediatrics for the mental health care of very young children and women who are pregnant with emotional difficulties. It would be fantastic if there could be a reform of the mental health system that is akin to how we approach cancer services, that there are things that the population health and the public health level for primary prevention, not that that's necessarily possible in mental health, but something similar certainly is. And there's tremendous resources in focus on detecting and preventing as early as possible just as there is with cancer. We should aim to prevent early in life - to treat early in life and early in disorder.

With regard to some of the finances, ideally there would be an end to rationing mental health care at least to the degree that it is currently, instead we cannot just activity based but demand based funding. How those systems would work I would advocate should be driven very carefully and closely by the clinicians who will be carrying them out because they're very difficult to do in a meaningful way unless with something like surgical services which it's a different matter in terms of the funding arrangements.

I might pause at this point to leave enough times for questions, of course, and I'll hand over to Campbell Paul to make some comments briefly.

ASSOC PROF PAUL: Thanks, Ben. Obviously we enforce what you are saying. I'll maybe just introduce a little more of my background. I'm trained as a child psychiatrist, I trained in Edinburgh and the Royal Children's Hospital where I've worked over the last 39 years, I think, but in a whole range of other areas as well. I'm a Life Governor of the Queen Elizabeth Centre which is an early parenting centre here in Melbourne and I was on the board of the Queen Elizabeth Centre for many years.

We initiated the post graduate training in infant mental health through the University of Melbourne and just recently have delivered a Master's course in infant and parent mental health. As I say I worked at the Royal Children's Hospital primarily in consultation with

(indistinct words) working with sick infants of the families but also families referred by a general paediatrician by maternal and child health nurses and by Child Protection. So a bit like, Ben, I've had a fairly broad experience around mental health work with infants and their families.

I guess I'd characterise our approach to infant mental health as one which is very cross disciplinary and hopefully I think integrated within the community. Our course in infant mental health, for example, the largest group, but not the majority, but the largest group doing the course were maternal and child health nurses. They would have social work, psychiatry, child psychiatry, people from childcare sectors so infant mental health as an academic group as a broad discipline is very much (indistinct words) community based and I think that's really important because we need to do as much as we can to identify infants and their families who are vulnerable and at risk and they won't be primarily coming through psychiatric services as such so I think it's an example of mental health being embedded in community response to families who are struggling.

There's considerable epidemiological data and then I'm sort of switching back to the sort of medical mental health psychiatry model looking at the epidemiology of identifiable problems but there's considerable epidemiological data to show that young children, infants from birth through to age three and four experience similar prevalence of mental health problems as other children and adolescents. There's a long running community epidemiological study from Denmark which shows that infants and young children, zero to four, experience mental health problems at around the rate of 10-12 per cent where there's a diagnosable disorder and I think it reflects the fact that the broad community, the professional community, have found it very difficult to accept to understand or acknowledge that infants and very young children can suffer significant mental health problems and this has been a longstanding issue for us to share with other professional colleagues but also with the community broadly that babies and toddlers can suffer emotionally.

People say, 'Oh, well they won't know anything until they can speak' or, for example, people are aware that there's a social smile that occurs at six weeks and parents will often still believe nothing happens in the baby's brain, in the baby's mind, in the baby's soul, before six weeks or 12 months so we see our mission as helping the broad community but also parents being able to put into words and respond to distressed infants. Rene Spitzer is a psychiatrist from Vienna after the First World War, between the two main wars, was especially focused on infant depression/infant withdrawal and through black and white film was able to demonstrate to professional colleagues how sad, depressed, withdrawn infants can become.

He suffered tremendous resistance and personal attack for bringing that information forward well into the latter part of his career which went into the seventies, 1970s, and I think it's still a big issue for us. It's very painful I think for parents and professionals to think about a baby, a toddler, as having severe emotional problems. The World Association for Infant Mental Health have produced an addendum, if you like, a supplement to the UN Charter on the rights of the child which is called the 'Rights of Infants' and we believe that infants have additional rights that are not fully covered by the UN Charter.

In particular the preservation of firm, safe secure attachments relationships, it's partly addressed in the UN Charter but we would really feel this is important to emphasise and we know that

there are thousands of - millions of infants and young children, pre-schoolers, who are in dire situations in refugee context around the world and they're often the last ones to receive acknowledgment and mental health input. That's probably enough of a statement but we can provide our statement on the Rights of Infants and the board of the World Association has got another document about the world wide burden of infant mental health which we're happy to submit to the inquiry if you would like.

PROF KING: Yes, that would be fantastic, yes.

DR GOODFELLOW: Something to mention very briefly, and I meant to do this when I introduced Professor Paul, is that infant mental health is something most doctors have never heard of, many psychiatrists haven't - certainly the rest of the community has a very large feel and one might think if he's somewhat of a niche specialty but that's very much not the case particularly here in Melbourne in Australia, there's a very large membership of the Australian Infant Mental Health Association and in fact Professor Paul in June next year will be taking over his president-elect of the World Infant Mental Health Association so for the following three years taking over at the World Congress which is to be held in Brisbane this year actually.

He'll be leading that organisation for the next three years so if there's one single recommendation or hope that I had for this hearing is that Professor Paul might be consulted widely by government and other leaders in the same way that there are some very senior accomplished well known psychiatrists guiding the government on youth and adult mental health policy, there's an excellent space in the 0-12 age group that Professor Paul could fill.

PROF KING: Would you like to lead off the question?

PROF WHITEFORD: Thanks, Stephen, very much for that, appreciated. So in some of the comments that you said in - you're suggesting there might be some recommendations that could be made about, relatively simple perhaps, that could make a change. If you had to make some recommendations or have us consider recommendations that could make a difference to the system that we've currently got given what you're describing as sort of the lack of attention to the, you know, infant mental health area, the perinatal area - what it would be? What could be different to make some changes in the right direction from your perspective?

DR GOODFELLOW: So it depends. Some of the simple changes that could make a difference come off - are based on the fact that, particularly if I speak from my experience in Melbourne and Victoria, most CAMHS services have relatively well-developed and well-functioning infant mental health services but it remains quite a puzzle to me why there are not more referrals made to these services and part of that is because of a lack of a general understanding and awareness within medicine, Allied Health nursing and the general community as for the place that psychiatry might hold and most of us graduate from medicine without much more of an idea of mental health other than maybe the five big diagnostic groups, something about suicide, psychosis and some of the medications. Psychiatry continues to be seen as a service of last resort and so it's only often months or years down the track when behavioural disturbance is getting right out of control and there's safety concerns people think, 'Oh, we better get the shrinks in'.

What we'd like to happen is that paediatrics, Allied Health and infant mental health work much more in tandem right near the beginning of a presentation in these fields. It's difficult to say precisely how that could happen. Part of it involves a lot more of the training and education of doctors and specialists who are not going to go on to become psychiatrists particularly in paediatrics and general practice but from my role on the board and my interest in systems work, part of the problem I think is that what we're measuring is largely not that important and we're certainly not measuring the important things across all of psychiatry but especially in child and infant psychiatry.

If we were, for example, to have KPIs measured in first instance we can leave targets for down the track once we know the patterns. If there were KPIs for paediatrics, family services, general practice, outside agencies, that measured how frequently they were contacting infant mental health services to discuss a case, something called 'a secondary consultation' which can seem informal and not particularly rigorous but is actually a very meaningful and complex intervention in itself.

PROF KING: Sorry, can I please stop you there. So if we're measuring the referrals though, the issue from what you've just said is that the people who you expect would make the referrals aren't picking up what the problem is or the need for the referral so what should they be picking up that they're not picking up that they're missing, what's the indicator to them that's missing - - -

DR GOODFELLOW: It's a great question and something that I say from time to time is that the demand for infant mental health services is hidden in plain sight because the problems that these children are having are picked up, it's just that they're seen so typically as being something in the realm of just needing a bit more childcare support or they're ascribed to a family social situation and unless, you know, there's more resources for the family there's nothing we can do about it. Moving further, many of the problems, arguably all of the problems, that a child could be referred to mental health for are they present with physical symptoms so they're first seen as a medical and a paediatric problem.

PROF KING: So what would have to happen to change that? What does the system need to do differently?

DR GOODFELLOW: So I think, this is the thing, it's the clinicians and people in the community are noticing that children and families need extra help but they're not considering infant mental health as being part of the time that could be involved and so if there was a KPI, how many referrals have you made to your local infant mental service? It's one of those drivers that managers would then begin to ask their teams about. You know, or they would take up the offers that CAMHS services have to come and have say regular monthly consultations with organisations.

PROF KING: It's a fairly (indistinct) measure though I would have thought.

DR GOODFELLOW: It sure is.

PROF KING: It's basically saying, you know, you can have referrals to mental health

services for infants (indistinct words) your target by referring completely to the wrong people. Is there anything better that we can do that's actually focused on, you know, the outcomes and mental health of the relevant infants?

DR GOODFELLOW: I think to have infant mental health specialists embedded within these or working much more closely within these organisations that are already seeing these children would certainly go a long way towards that but I might see if Campbell has a response to that.

ASSOC PROF PAUL: Yes. A few perspectives on this and maybe from a positive perspective to start with. Certainly in Victoria there have been some I think really exceptional initiatives around infant mental health and that is, building on the universal maternal and child health service, there's been some very exciting and innovative things. Professor Louise Newman and colleagues established a training program for maternal and child health nurses called 'MERTIL', M-E-R-T-I-L, and it's a face to face but largely online training for all maternal and child health nurses in the States focusing on infants, trauma and mental health. So there's I think an increase in awareness amongst maternal and child health nurses, for example, who will be seeing infants and their parents on a regular program basis as part of their service so there's an awareness.

On the other hand, delivering a targeted therapeutic intervention is a problem because there are limited specialist services. So awareness is there, service delivery is minimal. One way of I think addressing that is leadership from the health department. We had for quite a while a very strong group in the mental health branch advocating and organising services around infant and perinatal mental health. At the moment that group of leaders within the bureaucracy are not there and that's a lack so leadership from the health department I think would be really helpful.

In the UK they've had similar difficulties getting acknowledgement of infant mental health and they've got some similar mental health service structural organisational things in the UK as here and a group called the 'Parent-Infant Psychotherapy UK' which has now transformed into a broader organisation aware that all CAMHS services, for example, in the UK were funded to provide service not to a team. What they did was actually was surveyed them and said, 'Are you aware that you're funded to provide 0-18 services?' and I think something like two thirds to three quarters of the people said they were and another third or quarter said they didn't know that they were funded to do that. 'Do you have an actual program?' and then of the two thirds another two thirds it took about half of that group and then they asked, 'Do you have a program but you do actually see infants?' and the answer from again half of the group was 'No'. So I think a similar approach here would be really helpful, a reiteration that mental health services are funded publicly to provide service from 0-18 and to ensure that we actually do that in a rate that's proportionate to the population and which it isn't at the moment.

MS ABRAMSON: I have one really direct question which is really about stigma and the Commission - and it bears very much on what both of you have said to us. We made one recommendation about (indistinct) for emotional and social wellbeing and then of course people said to us, 'Well, you know, you're stigmatising. You're putting labels on children'; so how can we change that public perception? (Indistinct words) that you said the profession is

not yet aware that there are all these services and there are issues in very young children but also about the community so would we do there?

ASSOC PROF PAUL: And I think that's a really important one and it's to do with our language as well and we're often between a rock and a hard place. 'What's the evidence?' people say so you have to come up with some epidemiological about it which requires categorising infants and families in terms of, you know, real problems but in our clinical work we are at pains to try and minimise any sense of blame or stigma but I don't think it helps infants and parents to say, 'Well, there's not a problem' when there is and parents know that.

One mum came to our hospital, a major crisis in the family, with a toddler. In the middle of that she - there was an accident and the newborn baby was injured. The problem was it's especially intense for the parents around the toddler whose behaviour was getting increasingly difficult throughout the pregnancy. He kept punching his mum's belly saying, 'I don't want another baby'. She had to lock herself away to avoid getting angry with the toddler and to avoid him hurting her. The system response is, 'Well, that's just a toddler upset about the arrival of the new baby' but in the middle of that there's the new baby gets injured because of the distressing interactions within the family so I think we need to let the parents know that this is a serious and grave situation that needs additional resources to understand what's going on in the toddler's mind, what his experience is. Maybe he may even have an autistic problem. We need to be able to engage the parents without them feeling judged or stigmatised so that they can understand the toddler, the toddler/parent relationships and the impact that's having on them from the family.

From the paediatric context we've got a good (indistinct) that has the capacity to minimise stigma for some families to say - 'We're going to refer you to the child mental health service' and they'll say, 'Hang on, we've got a baby. We don't need to go to a mental health service' but - and I think that's where the collaboration, the enmeshment of our service within community services like maternal and child health at the Children's Hospital we have an instrumental health clinical embedded in the maternal and child health service so in two municipalities and we'd like to see it across the State. There's an instrumental health commissioner sitting in the consultation with the maternal and child health nurse so the family can see that the instrument health commissioner is a mental health trained person that doesn't have (indistinct words) and he's able to be part of a health care network that is responsive and thoughtful.

After the Second World War Donald Winnicott, psychoanalyst and paediatrician, made - the UK government was very concerned about parents losing their confidence after the war and, you know, there was immense trauma obviously and disruption in families and they asked Donald Winnicott to do series of radio broadcasts to parents about who infants are, what their role as parents is and they were really very powerful. He was a psychoanalyst talking to the ordinary people in the community and I think that's our job now to do something similar to be able to help parents see that their baby has a mind, has their own set of thoughts, feelings, intentions, desires, which can be railroaded - which can be impacted from birth injury from say an emerging autistic problem, that we can identify those problems early in life, early in the course of a problem, and without having - making parents feel that they are at fault or crazy. Intervene and help them, and I think that's where this business of being embedded in a

range of community services is so important.

The family violence work, we need to be there with family violence workers so they can understand what the toddler's experience is without making the mother feel she's driven her toddler crazy, but the toddler is depressed, withdrawn, avoidant, or has got major behavioural difficulties. If we're embedded in the services, then hopefully we can deliver something that isn't, as you say, frightening and stigmatising.

MS ABRAMSON: We would be really grateful to get a further submission from you, and if you could pay particular attention to what you talked about with us this morning, and we might come back to you as well.

MR CAMPBELL: Absolutely.

PROF KING: Particularly if you've got examples of things that have worked overseas, where we should look for programs in terms of that work, we'd be very grateful. So thank you very much, Dr Goodfellow and Professor Paul.

MR CAMPBELL: Thank you for listening. Thanks very much.

MS ABRAMSON: Thank you.

PROF KING: Excellent. Next we have Aurora Elmes and Krystian Seibert from the Centre for Social Impact, Swinburne. And again, if you just could state your names and affiliation, for the record, and then if you've got an opening statement.

MS ELMES: Sure. Thank you. So my name is Aurora Elmes. I'm a PhD candidate and Senior Research Assistant at the Centre for Social Impact, Swinburne.

MR SEIBERT: My name is Krystian Seibert and I'm an Industry Fellow at the Centre for Social Impact, Swinburne.

MS ELMES: So we will begin with an opening statement. The Centre for Social Impact, or CSI Swinburne, welcomes the opportunity to comment on the Commission's draft report on mental health. CSI Swinburne has particular expertise in particular expertise in social enterprise research, and social enterprises are businesses that trade to intentionally tackle social problems, and reinvest the majority of their profits back into their social mission.

A report on Finding Australia's Social Enterprise Sector notes that in 2016 there were around 20,000 social enterprises in Australia, and creating meaningful employment opportunities was the primary social purpose in just over a third of surveyed cases. Particularly relevant to this inquiry is the role of work integration social enterprise, and WISE is a social enterprise with a core purpose of providing employment opportunities to those who experience disadvantage in accessing employment, and this includes people with mental illness.

In response to the draft report recommendations on social participation and inclusion, we note that in s.20 of the draft report, the Commission highlights the relationships between socioeconomic disadvantage, stigmatising attitudes, and social exclusion of people with

mental illness. The report notes that social participation and inclusion are important to recovery, and reduce the risk of relapse. The Commission observes that work can benefit mental health and offer opportunities for social interaction, but identifies weaknesses within both the current employment services and psychosocial support systems.

There is a growing body of international research suggesting that WISEs address diverse forms of social exclusion by providing employment, increasing people's income and living standards, and providing opportunities for social connection and improved mental health and emotional wellbeing. WISE is a work integration social enterprises that involve meaningful interactions between people with and without mental illness. They also have the potential to reduce stigma, which we note is an aim of draft recommendation 20.1.

Section 20.2 of the draft report includes three pages on social enterprises as a possible pathway for promoting social participation and inclusion, but the report stops short of making any related recommendations for s.20.2. We wondered if there is any further information the Commission needs to consider recommendations for this reform area. I'll just continue on, and then I'll leave plenty of time for questions.

So alongside social participation, employment has been a key focus area of the draft report, and in response to the draft report recommendations on increasing participation in work, we note that draft recommendation 14.3 suggests further rollout of Individual Placement and Support, or IPS programs, to support people with mental illness into employment. While several evidence reviews have found IPS to be more effective than other vocational rehabilitation programs, a recent randomised control trial comparing a social enterprise with IPS found that social enterprise was similarly effective in generating positive employment, mental health, and housing outcomes.

Draft recommendation 14.3 states that, 'Government should thoroughly trial and evaluate the IPS program.' And recommendation 22.5 notes the need to build a stronger evaluation culture. We support these recommendations for ongoing evaluation, and believe there's enough evidence to consider recommending further comparative evaluation of WISE outcomes. We encourage the Commission to consider making specific recommendations for s.20.2, about what government can do to support social participation and inclusion, and to consider further evaluation of WISE as a way to facilitate employment and support social inclusion for people with mental illness. Thank you.

MR SEIBERT: And I don't have anything further to add.

PROF KING: Yes.

MS ABRAMSON: I'd like to know what you think those recommendations could be.

MS ELMES: Yes. So I was interested, because the report does go into quite a lot of detail about potential approaches to supporting social inclusion, and I did note that there is an associated recommendation 20.2, but that specifically refers to increasing access to insurance for people with mental illness. So having, you know, looked at the comments that the report has made, it's clear that while it's recognised that there's a role for psychosocial support

services and, in chapter 12, there's some detail around trying to address some issues around NDIS access, or access to psychosocial support for people who aren't eligible for NDIS.

There's evidence in terms of social inclusion that not only formal services are needed, but opportunities are needed for people to have spaces that they can go where they feel accepted, that they're able to form organic social relationships and have opportunities to build friendships. And so, part of that, I guess, our work does focus on social enterprise and work integration, social enterprise.

Part of that is looking at what organisations within the community can do to provide those spaces, and that may go potentially beyond more traditional formal support services to looking at where else people can be offered that opportunity to go and have a place to connect and be accepted and participate in a way that's meaningful to them.

MS ABRAMSON: Could I ask a follow up question? In terms of who might drive that particular outcome, are you thinking about NGOs, or are you thinking about local government?

MS ELMES: So I think there's a part to play for a number of different organisations. Our work does focus on social enterprise, so essentially, they are sort of trading organisations that have a social purpose. But I think there's a part to play across a range of different organisations. With a complex issue like this, it's not just about one actor playing their part, I think it is about the whole of community approach, and potentially with social enterprises forming one part of that.

But I think one of the key recommendations or key things that we'd like the Commission to consider is, I guess, continuing to build the evidence around what are the effective approaches. Because having looked at the social inclusion sections of the report, and having read some reviews on what is effective in terms of social inclusion for people with mental illness, there actually seems to be a little bit of a lack in evidence, and I think there's an opportunity to build more of that in terms of both evaluating IPS approaches and comparing what are the effective - the outcomes of effective work integration social enterprises.

But then perhaps also going back to look at the research literature and see if there are areas that need to have more evidence built around what's effective.

MR SEIBERT: And just to add to that, I think, like with any complex problem, it involves a multi-sectoral approach, and if we look at the case study of Vanguard Laundry, which Aurora is leading the evaluation of, it's - it itself is a charity, a public benevolent institution, but the funding it received to establish itself, it received philanthropic support, it received government funding, from both the Federal government, and I think from - did it receive state government as well?

MS ELMES: No. Just Federal.

MR SEIBERT: From the Federal government. But then, in terms of getting an anchor client in order to provide it with sort of that sort of initial kind of contract to be able to get

itself going, that was a hospital provider. So there really is sort of a multi-sectoral approach, coordinated approach.

PROF KING: Sorry, just a clarification question. You mentioned a recent publication comparing WISE, the planning of WISE, has similar results to IPS. Is that the Kirsten - sorry, Kristin Ferguson - - -

MS ELMES: Yes, that's right. So as far as I'm aware, there's only so far been that one randomised control study that does look at social enterprise and IPS approaches. It found that after, I think, a period of 22 weeks, participants in the social enterprise arm had 39 - 39 per cent of them had had any paid employment in that time compared to IPS; I think it was around 30 or 32 per cent.

So what that research has recommended is they've said, because it is a small study, it's a initial randomised control trial, there is a need for further evidence to look at - to really build a strong evidence base for that. But I think because it's - at this stage, there's very little evidence on that, and it is inconclusive, and we're aware of these outcomes that WISE can have in terms of giving people an opportunity to feel capable, to hold valued social roles, to connect with others.

We do believe there's an argument for essentially continuing to monitor the social enterprises that are in existence already, and potentially try and aggregate some more of that evidence, or look at whether there are situations in which potentially a social enterprise could be a good fit for a community of they are needing a particular service, or there's a gap in the market, or there's a need for people to have a place to gather, compared to other sort of more intermediary approaches that - like IPS that look at what are the jobs that are there, and how can we fit people into those jobs.

MS ABRAMSON: And could I ask two things? First of all, we'd really - as we said with the previous speakers - really welcome a further submission from you, particularly around work integration, social enterprise, and costs and benefits. And also, could you tell me, does the IPS model and the social enterprise, is it the same cohort of people that they're looking to support? Or are there some differences?

MS ELMES: There may be some differences. So I think, you know, like any group of people, people with mental illness are very diverse.

MS ABRAMSON: Very diverse, yes.

MS ELMES: And so I can speak, for example, from the perspective of having done the research with Vanguard Laundry Services, the group of people that they're working with, I think for IPS, there's a chance that people who do sort of put their hand up to be part of an employment support, or employment services program like that, are potentially people who are closer to the open labour market already.

MS ABRAMSON: Yes, yes.

MS ELMES: They're sort of motivated, they're looking for work, they may - potentially may have more readiness to undertake that, or more confidence to undertake that. A group, for example, like Vanguard Laundry Services is more mixed in terms of supporting people into employment who may have never worked before, may have been out of work for 20 plus years, may have been told that they can't work because of their mental illness.

And I think that - I think in those cases, potentially there can be a place for work integration, social enterprise as being an environment that is specifically set up to support people, and understands the issues that people my face, and is able to support people, whatever stage they're at. Whereas, you know, we don't know, I think, at this stage whether IPS can be as successful, because there's just not evidence at the moment. So I think it's about understanding that.

MS ABRAMSON: Well, thank you so much for your evidence today, because it's really a really interesting area, and we'd really welcome very strongly some - a written submission from you.

MS ELMES: Thank you.

PROF KING: Harvey, have you got a - - -

PROF WHITEFORD: No, no, no, it's been covered. Thank you.

PROF KING: And so, just to make sure we've got the Kristen Ferguson paper, if you could just - - -

MS ELMES: Yes. Sure.

PROF KING: - - - shoot through the exact reference, that would be great.

MS ELMES: Absolutely. Thank you for your time.

PROF KING: Thank you very much.

MR SEIBERT: Thank you.

PROF KING: Thanks very much. Next, we have Jade Chandler. Thank you. Thanks, Jade. And again, if you could state your name, if you are representing any particular body, which body, and if you have an opening statement.

MS CHANDLER: Great. So, my name is Jade Chandler. I'm a mental health nurse, and my role at the Australian Nursing and Midwifery Federation, the big branch, is Mental Health Nursing Officer. So my role is to represent the mental health nurse workforce across the state, and I would like to make some points in regards to the draft report. Thank you very much for the opportunity.

So we would like to thank the draft report in regards to identifying that there is a greater scope in regards to the role of the mental health nurse across the whole workforce, and not

just in hospitals, as well as mental health peer workers. I wanted to touch on some early intervention, because we'll scope in a little bit about stigma today, and identify some of the workforce that is already there and able to be potentially expanded.

So one of those is the maternal child health nurse program. So, as we know, the maternal child health nurses, whether they're the universal or the enhanced, maternal child health nurse have the capacity to do those 10 visits between birth and school age. So I think by adding in some mental health screening in regards to that, that could identify opportunities early in regards to following up on any flags, as well as at school age. So we've got the school nurse program.

So, at the moment, it is mostly general nurses. However, there's an opportunity to expand to mental health nurses, so that would be both in primary schools and secondary schools. Identified in the draft report is the need for wellbeing leaders in schools. I think nurses have that specialty. We don't want to give more teachers - or teachers more work to do. We want to be supporting teachers in what they do, and by having mental health nurses in schools, it helps that conversation, that prevention, and building, I guess, resilience in regards to that.

So these are models that are already there. In regards to the education of mental health nurses, I note that the - there's a recommendation in regards to an undergraduate mental health degree. It is the branch's position that the postgraduate model is better. It works well at the moment. I note that there's a comparison in regards to midwifery, which is in Victoria. I think that, as we've spoken again today, there is a stigma around mental health that doesn't really allow the capacity to have that attraction that a midwifery direct entry course has.

I can tell you from my personal experience, I didn't have a lot of exposure to mental ill-health until I was into my second year of nursing, and it wasn't until - excuse me - I participated in an undergraduate placement in mental health that I really sparked interest, and I think that that is the case for a lot of nurses, that they don't have that exposure, and it's not until they work, whether it's in community mental health, or an in-patient unit that they understand the work that mental health nurses do, and it sparks interest.

I also think that the three year nursing bachelor followed by the postgraduate qualification in mental health, it gives the mental health nurses the ability to provide that holistic care and have that - both the physical expertise in regards to the physical health, as well as mental health, and it gives us the edge on other workers, I think. So I wouldn't want to have that watered down.

In regards to other opportunities, I think that a lot of organisations have made submissions in regards to the Mental Health Nurse Incentive Program, which was a successful program, cost-effective, it was evaluated to be quite strong, and unfortunately, the funding was lapsed many years ago. The benefit of that program was that the nurses working in the community in a less intrusive environment were able to work long-term, so up to two years, with consumers, both their physical health as well as their mental health. So I think that that really needs to come back.

The final thing that I would like to suggest is, I note in the report there's themes in regards to access and navigation of mental health services. One opportunity, and this is something that

the branch has put into the - submission into the Royal Commission into Victoria's Mental Health Services, is to adopt the Queensland Health model of Nurse Navigators, which has the capacity of, I guess, creating that partnership with the client, providing a central point of communication and coordination for the clients and their families, as well as coordinating that timely access.

Because we all know that, at the moment, it's such a difficult service to navigate if you don't it, if you haven't had that experience working in it. So that would be a suggestion as well. And I think that's it.

PROF KING: Harvey.

PROF WHITEFORD: I'll just take you back to the question about undergraduate versus postgraduate is obviously a tricky area. Could the two co-exist or is that going to create problems within the nursing profession or for employers or consumers/families?

MS CHANDLER: I think it has the potential to create a divide in the workplace so there already is a divide in regards to the support of it, the undergraduate model and the benefits of the postgraduate model. There's also already a divide in regards to the credentialing which is a voluntary process and not required in regards to industrially or registration. There's already tiers in nursing as well with the enrolled nurse and the registered nurse. I think that it is the potential to divide the workforce even further.

PROF WHITEFORD: Can I (indistinct words) we might be jumping around topics a little bit.

MS CHANDLER: No, that's fine.

PROF WHITEFORD: The maternal child health nurses. To what degree would they need additional - well, so you've said include or you suggested that maybe it could include mental health screening in there, would that require additional training? Would that require a change in training? How do you see that being implemented on the ground?

MS CHANDLER: I think that there would be at least initially minimal training in regards to the screening process and then in regards to follow-up from that, so whether they're referred to the enhanced maternal child health nurses who already have that complex ability to look after complex families that may or may not have mental health issues or at risk of mental health issues so it might be that that screening highlights that area or that need earlier than is later highlighted. It could be that there's more enhanced maternal child health nurses because they already do a lot of great work with families with or at risk of mental health issues.

PROF WHITEFORD: Yes, okay. Now, that's sensible.

MS ABRAMSON: I feel like I keep asking questions of all the participants about stigma but you did mention that for many nurses it's not seen as an attractive career option and I'm just really interested in any ideas you have as to how we could make it a more attractive proposal because you noted in our report that we're very strongly of the view that we'd like to see more mental health nurses.

MS CHANDLER: Yes. I think that at the moment the mental health nurse workforce struggles with a lot of occupational violence and aggression and that is often seen in the media which has, you know, the capacity to put any potential nurse off so we need to fix that and that's something that unions/workplaces are trying to do and it takes a lot of time. I think that often again addressing - it's a little bit difficult - addressing the school age and university aged through - I guess some type of mental health promotion? Yes, I don't really have a whole - it's a big thing stigma and I don't really have an easy answer for you that would - - -

MS ABRAMSON: We'd encourage you, I guess, if you're making another submission.

MS CHANDLER: Yes.

MS ABRAMSON: Perhaps you could speak to the member and we'd some thoughts on that.

MS CHANDLER: Yes, of course, yes.

PROF KING: Can I just follow up on that because one of the reasons why - we've got the draft recommendations suggesting that alternative undergraduate (indistinct), we have feedback about stigma as part of the training process, in other words where the undergraduate degree of nursing there was a view put forward to the students, and I'm not saying this is all programs, but it was certainly put to us that it's certainly through some programs, students were told, 'Well, you don't want become a mental health nurse, you need to be a real nurse. If you're thinking of doing that do real nursing' and very much - so there was a stigma, a professional stigma, as part of the training which is why we perhaps thought separating that off would help but now obviously you've got different views on that. But I'd be interested in your views on that, the stigma during training.

MS CHANDLER: Yes, yes. Obviously there are some universities that are better than others in regards to that academic view as well as even entering the grad program, that can be in the workplace as well so it's definitely a hurdle. One thing that we're trying to encourage is, I guess, transition to mental health so for those nurses that were maybe discouraged from going straight into mental health, they have felt like they've lost their opportunity that they've got that opportunity to go and spend 12 months whether they're enrolled nurse or a registered nurse in a mental health to experience it and see if that's what they want to do so that's just something to address the result of that, how to prevent that is maybe just making sure we've got the right academics teaching them into health units as well.

PROF KING: Do you think there should be or there could be curriculum changes in young graduate nursing degree (indistinct words)?

MS CHANDLER: Potentially but I guess it's a fine balance in regards to, you know, we want to have the physical skills in regards to providing that holistic care so we don't want to take away from that but we don't want to have the right mental health unit, I guess, educated so it's a fine line. I think it's probably the quality of the placements because we know there's so many students looking for mental health placements so an inpatient unit is great in regards to experience that but some might be able to do the same in the community and see a

different type of mental health because the acute end is not what every nurse wants to do so there's (indistinct words) spectrum in regards to that.

PROF KING: Thank you for that.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Thank you.

MS CHANDLER: Thanks

PROF KING: Next we have Associate Professor Alan Young. And again if you could state your name, affiliation and if you have any opening remarks.

ASSOC PROF YOUNG: Sure, thank you. So my name is Associate Professor Alan Young. I work as a sleep and respiratory physical here at Eastern Health in Melbourne in a public system but I'm here today with my hat on as president of the Australasian Sleep Association and I do have an opening statement if you actually have time to hear that, thank you. So first of all thank you very much for the opportunity to present at this public hearing today and also I want to commend the Commission for the sort of comprehensive report (indistinct words) innovative reforms to improve the mental health and wellbeing of the Australian population.

In advance I forwarded two documents so the first is the ASA submission to the Commission which is submission 96 which is a document, a 13 page document, with about 50 references and it highlights a large body of scientific evidence linking mental health to sleep loss and sleep disorders and this may have relevance to the report because it outlines sleep disturbance and sleep disorders as risk factors for the development of mental health disorders and importantly avenues for cost effective early intervention and treatment to prevent the development of mental health disorders.

The second document that I've forwarded was the parliamentary inquiry into sleep health awareness which is called 'Bedtime Reading' so I'll refer to it as 'Bedtime Reading'. This was recently handed down, it's a new development in April 2019. It was called the Federal Health Minister, Greg Hunt, as a standing committee on health, aged care and sport chaired by MP Trent Zimmerman carried out the report. It's completed, it received over 130 submissions and has bipartisan support and it has 11 recommendations for improving sleep health in Australia and the first recommendation is sleep is recognised as a national health priority as a third pillar of good health along with diet and exercise and two quick stats from that report: 'Four out of ten Australians are not getting the sleep they need with an annual cost to the economy of \$66b'.

There are three further key recommendations that the ASA and our sister organisation, the Sleep Health Foundation, are working to have implemented which has relevant to the current Commission report, synergies with the current recommendations from the mental health report, specifically in the areas of early intervention, prevention and workplace safety. In terms of my search of the current report I couldn't, current mental health product, I could find

no reference to 'sleep/health' within that or the ASA submission but there is a consistent reference to the word 'sleep' in the section on 'homelessness' in relation to sleeping rough.

So in the interests of time I'm just going to briefly mention three areas that highlight that mention health and sleep are inextricably linked with a complex bidirectional relationship between mental health and sleep. So the first is insomnia and depression so I've reference all of the following comments: so insomnia affects up to 10 per cent of the adult Australian population and is a significant predictor for the development of depression so recent meta-analysis showed there's an odds ratio of developing depression in those with insomnia.

And depressed patients with insomnia have a worse response to treatment with higher relapse rates and depression also predicts the future risk of insomnia so that's bidirectional. So the goal standard treatment for insomnia, which is cognitive behavioural therapy, is evidence based and cost effective yet only 5 per cent of patients presenting to GPs receive this appropriate treatment and 90 per cent receive a sedative prescription, that's evidenced from the BEACH reports which is probably inappropriate first line therapy for insomnia.

So in patients with insomnia and depression CBT is as effective as antidepressant medication for treating depression, and all of these I've listed references - if you want me to quote them or I quote them from either Cunningham or Shapiro 2018, early detection and treatment of insomnia with or without comorbid depression then is likely to have a significant impact on reducing the burden of disease related to depression'. So that's one key area I wanted to highlight.

The second is sleep loss in children and adolescents. So poor sleep is linked to 'poorer current and future mental health, that's a quote from the Vic Health Promotion Foundation, 'adolescents are well recognised to have delayed sleep phase' so their body clock is delayed, their (indistinct words) is delayed, they go to bed later and get up later and of course it's an intrinsic physiological problem and they have social pressures related to bedtime where there have some sort of electronic devices so 10 to 30 per cent of adolescents have sleep problems.

And sleep interventions in school can improve sleep and mental wellbeing and I've got a quote there; Patterson behavioural sleep medicine 2017. Additionally poor sleep is a risk factor for suicide. A recent systematic review sleep disturbance was associated with increased impulsivity and increased risk of unplanned suicidal behaviour. The reference is Porras-Segovia 2019. And I've got a couple of quotes from the National Mental Health Commission and their quotes are taken from the 'Bedtime Reading' report. They stated, I'll quote:

Clear and compelling that indicate the close link between sleep health and mental health and explained that sleep deprivation can further contribute to the development of mental illness by lowering an individual's resilience to respond to mental health problems.

They went on to draw attention to research indicating, and I'll quote:

A strong correlation between sleep disturbances and suicidal ideation and behaviour and they cited a 2017 study which found that "sleep problems worsened suicidal thoughts in the days and weeks preceding a suicide attempt or suicide completion and they added that

complaints about sleep may serve as a warning sign and key risk factor while providing an avenue for early intervention and prevention

So those quotes are taken from the Bedtime Read report, p.20. And then the final area I'll quickly mention is the relationship between work, sleep and mental health. So longer working hours associated with poorer sleep and increased symptoms of depression and anxiety: 10-15 per cent of Australians are shift workers, often safety critical occupations such as emergency workers, working in health, commercial drivers; sleep loss and circadian misalignment resulting in shift work sleep disorder characterised by work accidents, lowered mood, anxiety and increased cardiovascular risks and standardised appropriate work hours are critical to maintain mental health and the reference for that is Alfonso, occupational medicine 2017.

So I noted with interest the Commission report in s.19.2 talked about psychological health and safety in the workplace and so workplace health and safety laws employ a code of practice in return to work, are areas I think have overlapped with sleep. So just in closing, in terms of suggestions if you're happy to hear them. A suggestion would be that potentially the report could recognise the importance of sleep loss and sleep disorders such as insomnia as a significant risk factor for the development of mental health disorders and I noted those were covered in Volume 1, the risk factors for mental health disorders.

The second suggestion is the education and intervention program in the step care model which runs across from patient self-help to lower level intervention to the psychologist specialist, could include education about sleep loss and sleep disorders at all those levels from patient all the way up to specialists and I quoted some - you know, the issues with GP education and training of psychologists in sleep. The third suggestion is that the early intervention recommendation for schools could include sleep education for teachers and students and asking about sleep-related problems.

And then the second last suggestion I think is there's synergies between the parliamentary inquiry report into sleep so I just wanted to mention three recommendations which I think could be helpful. So the first is we've currently applied for government funding for three of these recommendations: national public behavioural change campaign to improve sleep health awareness'. I think public awareness of sleep would be very helpful. That's recommendation eight.

There's also application for primary care practitioner education program related to sleep health. That includes GPs, nurses, psychologists and pharmacists, that's recommendation nine. And also within the report there's workplace safety guidelines to have standardised working hours and shift work safety guidelines that are Australia wide and that's recommendation two and three within the inquiry and I don't know if it's within the scope of the reports to look at recommendations from other reports and sort of - - -

MS ABRAMSON: Absolutely.

PROF KING: Yes.

ASSOC PROF YOUNG: That would be extremely helpful because I think there's synergies there. And then the final suggestion is ongoing training and funding for psychologists and in sleep disorders and with improved access for CBT-I such as, an example, the NHS in the UK now has since 2018 a program with online access to CBT-I. So sorry to take that long but that's my - - -

MS ABRAMSON: No, no, that's very helpful.

PROF KING: Very good. And in fact you've sort of cut off my initial question at the pass so thank you very much for that by referring to a number of recommendations of that parliamentary inquiry. I did want to - what you didn't mention was recommendation four which talks about the barriers to accessing cognitive behavioural therapy for insomnia which will review the MBS to see if it's (indistinct). Do you know if work is progressing in that area?

ASSOC PROF YOUNG: Look the stage, with my ASA hat on, the first two recommendations - because we're taking them step-wise rather than trying to get all 11 recommendations simultaneously through so we focused on the behavioural change campaign really and primary care education but within the primary care education is for further education of psychologists but we haven't gone down the MBS (indistinct words) but we will be making our way through all of those recommendations and there's some work being done with NHMRC (CRE) on alertness and productivity into the shift work issues and national standardisation.

PROF KING: And just before I pass over to my colleagues. You mentioned the I-CBT - I think you mentioned in the UK?

ASSOC PROF YOUNG: Yes, yes, so the NHS. (Indistinct words) in NHS since 2018. They've put a priority in having availability of psychological services which includes, you know, greater access to CBT for insomnia and one of the things they've implemented is - because there are online CBT-I programs available but for a cost and so they've now provided for free online CBT to certain sections of the population.

PROF WHITEFORD: Okay. Do you know if any of the ones related to sleep are embedded into broader online programs - you'll notice one of our recommendations is the expansion of online moderated mental health interventions, I don't know if you call them CBT-2, because they're broader than that.

ASSOC PROF YOUNG: Yes, because it goes much higher than that actually.

PROF WHITEFORD: Do you know if any of the sleep-related ones are embedded in those broader programs or are they (indistinct words) standard one?

ASSOC PROF YOUNG: Look, within Australia because ASA we have a role in providing sleep education, that's one of our main roles we've got programs set up with the Royal Australian College of GPs so we've got sleep modules, which are CME accredited to look at, and one of them is on insomnia.

PROF WHITEFORD: Yes.

ASSOC PROF YOUNG: We've also got with the Australian Psychological Society there's a sleep certificate in sleep medicine, a several hour training module with the APS so we do already have the beginnings of some of the sleep education tools but our funding asks for the primary care is to roll those out. You know, we can reach 600 GPs every two or three years using the RACGP and we need to reach 10,000 GPs so that's where we'd - you know, any assistance or, you know, in terms of promotion broader reach of those education programs for GPs, psychologists, would be very helpful and appreciated.

PROF KING: Lovely. Do you have - - -

PROF WHITEFORD: I think that was a very good presentation actually so the online CBT that is in the sort of I guess the mainstream of mental health so treatment where the target is to treat, you know, common anxiety and depression as far as you're aware those programs don't have the sleep component built in the sleep (indistinct words).

ASSOC PROF YOUNG: That's a good question. I'd have to check with one of my colleagues and I think later on in Tasmania my colleague who's the President of the Sleep Health Foundation works very closely in that area with a psychologist background so she may be able to answer that question specific. I suspect there will be a sleep component but certainly not the comprehensive level that you need to achieve, yes.

PROF WHITEFORD: Sorry, so a recommendation to enhance that would be a way of (indistinct words).

ASSOC PROF YOUNG: Absolutely and I'm not sure what the Commission has planned in terms of your - because I read about your plans for online programs and I'm not sure what's in that so whether that has a - so that's one of my points just to make sure there's a basic sleep component in that so that - because it's so closely linked into ask about sleep problems and to, you know, implement measures for sleep probably appropriate as needed but the other programs I referred to are purely just CBT for insomnia, they're standalone.

PROF WHITEFORD: So I guess my perspective coming from my training is that the sleep problems are secondary to the mental problems but what you are highlighting is that the sleep problems can come first and be risk factors for them and you've got to cover both.

ASSOC PROF YOUNG: Yes so all of - and I'll forward you all the references but, you know, these are all recent references so the concept now is it's bidirectional. It's not, it's the converge of the other and so, yes, insomnia can precede the development of depression and so intervening early is clearly a way to prevent mental health illness.

PROF WHITEFORD: That's good, thank you.

MS ABRAMSON: I had one question, Associate Professor, and that was really about how many people do see their GP and anecdotally I would have thought it was quite common for people to go to the GP and you've said to us there is another method, they could be

recommended the CBT and they aren't and we're very keen on GP education so I'm really interested in (indistinct words) what you say.

ASSOC PROF YOUNG: Yes, so insomnia is the commonest sleep presentation to GPs and I think it's in the top ten for reasons to present sleep-related problems to the GPs and that's date from the BEACH Report. The issue is GPs in medical training there's about two hours of training devoted to sleep cross the entire program so that's been surveyed in Australia and Asia Pacific as well and so the problem is that a GP's potentially not equipped, you know, to manage these because it's a complex problem. You know, someone may present with insomnia and depression and work stress so the issue is that as I mentioned only five per cent of the patients presenting to GPs who could be appropriate to receive cognitive behaviour therapy and some received that referral but it's skewed towards, you know, prescription of medication. About 90 per cent receives sedative medication. Now, that's data is about ten years old so it may have changed, it hasn't been reviewed again recently, so we would like to see a shift away from sedative medications towards CBT and referral to a sleep psychologist for management of insomnia in selected cases.

MS ABRAMSON: Do you think that part of that is about community expectations when people have insomnia they go to their doctor and they expect to be given, you know, medication for it?

ASSOC PROF YOUNG: You're right. I think it's multifactorial; there's community expectations, there's short consult times for GPs which, you know, it's quick, it's fast to prescribe a medication than do a full sleep history and social history and so on, psychosocial assessment, so I think there's multiple factors but I think, yes, educating GPs is one, educating the public is another and those are those two recommendations. Insomnia is a huge part of our, you know, obstruct sleep apnoea insomnia are two (indistinct) that we want to educate the public and primary health practitioners to improve but it will have flow on effects to mental health I think if we can implement those programs.

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

ASSOC PROF YOUNG: Great, okay. Thanks very much for the time.

PROF KING: Thank you.

PROF WHITEFORD: Thank you.

PROF KING: And next we have Louise Glanville from Victorian Legal Aid.

MS GLANVILLE: Good morning.

PROF KING: And if you could just state your name and your organisation and if you have any opening comments for the transcript.

MS GLANVILLE: Thank you very much. My name is Louise Glanville and I'm the chief executive officer of Victoria Legal Aid. Victoria Legal Aid employs about 900 staff, the majority of whom are lawyers and we act essentially for people who are very disadvantaged

and very vulnerable in terms of defence lawyering particularly in the indictable and summary crime spaces. In the civil spaces we are very involved with disability-related issues, mental health-related issues, issues to do with immigration, issues to do with income security.

In the family and children's law area we work clearly with federal legislation in relation to family law generally in relation to child protection, that covers probably most of our primary areas at Legal Aid. Importantly over the last probably five to six years we have really grown our practices that relate to mental health, we have a mental health legal team as well as a non-legal advocacy team called IMHA that you might be familiar with which I think you are from your interim report and I can speak to this further but this talks to the importance for us of having both legal representation and non-legal information for people when they're dealing particularly with mental health issues.

We see each year about 100,000 unique clients. 'Unique' means that there are many of those that would contact us more than once but generally 100,000 is the figure that we would use and of those about a quarter would identify as having some sort of mental health issue. We believe this is an underestimate of the reality of the situation but certainly one of the critical issues for us is that we see the intersection between a range of issues that we deal with, whether they're in the civil space to do with those that I've mentioned or indeed housing or others or in the criminal space, summary and indictable crime in relation to people also experiencing mental health issues.

We're very pleased to see that the Commission's adopting a system wide approach to this issue. I think it's particularly complicated but I think one needs to consider my within a systems context and understand the way in which a range of issues intersect and impact on someone's mental health so psychosocial issues, housing issues, employment issues, support issues and in that way we very much commend the Commissioner for essentially that approach. We believe that essentially, and I'm speaking primarily from Victoria, of course there is also a Commission going on here in Victoria and we have provided advice to that Commission on what we are seeing on the ground but very clear that often people have to really be in crisis in order to get the assistance they need and so we are really advocating for a system which not only responds to crisis but more holistically deals with prevention and early intervention particularly in the community space and other spaces before people are picked up as a consequence of really falling off the end of that particular cliff.

As part of that we think housing remains a very significant investment for all governments to be thinking about. It is very disturbing to us when we see clients who can't perhaps go out in to the community after they've perhaps had a term of imprisonment or been in a hospital in a secure space because there are not the appropriate sort of options for them to be able to access to get the support and to enable them to be on a recovery journey and I suppose that is a primary orientation we have that we think the mental health legislation in every jurisdiction, and ours included here in Victoria, needs to focus more thoroughly on sort of the journey, the recovery process, as distinct from the crisis responses that currently we think primarily occurs. This is important also, because we really want to enable people to live healthy lives, and to make a contribution to the community.

And I think there are more Productivity Commission reports now in a whole range of areas; it could be - NDIS is one good example, and the work that the Commission did on that many

years ago now, which indicates that if we have the right systems and supports in place for people, they can become more included in life, they can contribute more fully, their carers can contribute more fully to their own lives, and all round, governments probably across Australia would continue spending the same money that they do on mental health systems, and mental health issues, when in fact, we could be really looking at the sorts of productivity that could help people contribute to life more fully when they're suffering from a mental health issue of some sort. So I think this is a particularly important point.

We also support that intersection with other systems, and I draw your attention to the income security system, which is also one that we come across many, many of our clients experiencing difficulty in that space who do have a mental illness. The robo-debt challenges that we're currently running is key part of what we've seen, where people are - experiences a system that is complex and confusing and requiring to people - people to pay money that in our view they don't actually owe, as we've now shown in several instances. So I think that focus is good as well.

And importantly for us, we try and practice at Victoria Legal Aid the importance of serious, proper, and early inclusion of people with mental illness in helping design the sorts of responses that we should have to the issues that they raise. It's terrific the Commission has picked up on this as well. I think we are well and truly in Australia in an era of youth centred design, and I think we need to understand what this means for well-developed systems, and how in fact those systems can better respond to the needs that people have.

Finally, I perhaps want to touch on what we would see as mental health issues and the connections with the criminal justice system. It is of deep concern that we do see people who come in contact with the criminal justice system because there has not been, in my view, appropriate supports for them on their journey, and perhaps their demise is a consequence of the mental health issues they're facing, and in this way, I think we have some very important work to do as part of this Commission, and indeed, the one in Victoria, in thinking about how we can properly support people so that their trajectory is not one of diminishing, but one of growth contribution and inclusion in communities.

And so I commend the Commission, and so does Legal Aid commend the Commission for the work that it's doing, and I would like to perhaps just end with a quote from one of our senior consumer consultants. So we engage people who themselves have lived experience of disability and mental health issues. We have advisory committees that support this, and this is a comment by Linda Bennetts, who said, and it's included in part of our materials, 'Now is the time for a total rethink and genuine cultural shift. We need more services, better services, and importantly, we also need alternative services.'

'Let those of us most impacted by the system lead the way in designing a new system that works for us. We want services that are amazing, that you would consider good enough for yourself or your families or your friends.' And I find that particularly poignant, and I think there are many stories that are included in our submission in which we could provide to you, of course with the consent of the relevant owners of those stories, that attest to the ways in which your thinking that contribute to that actual vision. Thank you.

PROF KING: Thank you very much for that.

MS ABRAMSON: All right. Thank you. Thank you very much, Ms Glanville, and can I also, on the record, thank your staff for the help that they have provided the Inquiry.

MS GLANVILLE: Thank you. Most of them are here, I think.

MS ABRAMSON: Thank you. I'm going to give you the invitation to take up on your last point, because you will have noted in our report that we really - one of the difficulties for the Commission was, because it was part of a very broad report, and we were looking right across Australia.

MS GLANVILLE: Yes.

MS ABRAMSON: So we did see - we spoke very much about diversion and trying to prevent people coming into the criminal justice system. We spoke about what happens when you're in jail, and also on release. But I'm really interested in taking up your last point about, well, what can we do differently, and your views of some of the diversion programs.

MS GLANVILLE: Yes. So in Victoria, I think we have quite a proud history of therapeutic jurisprudence, or what I would call sort of more commonly, problem-solving courts. This isn't the person who's the problem, it's the things they're experiencing that are the problem. But I think this is a very important piece of any justice system in any jurisdiction.

So courts such as the - perhaps the Neighbourhood Justice Centre, or the Family Violence Courts, or the ARC List, which is the Assessment and Referral Court, look not just at perhaps the offending that the person has done; that's clearly why the person is there, but they also look at the needs that this person might have that might have contributed to the offending, and it is very clear that it is a slippery slope for some people when their social issues become overwhelming. They perhaps don't have housing. They perhaps have fines that they cannot pay. They perhaps sleep out quite a bit.

They perhaps get picked up for what we would call quite minor crimes, such as perhaps stealing a small amount of petrol from a petrol station for a bike, or whatever it might be. It's very easy to see how these people can become involved more thoroughly in the criminal justice system, and in this way, the broader causal factors, what I would call the social factors, of their lives don't get taken into account enough. And I think the worst thing for most governments is to have many, many people in prison, because we know that this is not only expensive, but often it doesn't produce very good outcomes for those that are there.

So the courts like the Assessment and Referral Court in Victoria, it looks holistically at the person. Where are they living? Do they have a mental health issue? Are they employed or not? Are they included in life in a sort of a real way? And this process happens; it's a diversion from the court. This process happens, and then it's still part of the court, but the matter then comes back before a magistrate or a judge, as the case may be, with much better information about what this person is experiencing.

And in that way, I think those sorts of diversions based on problem-solving approaches and therapeutic jurisprudence, as I would call it, have really shown to be very efficacious. I also

think that some of the approaches that Legal Aid has used in the civil space are very good in this respect. So we go to every - we're in every public hospital in the state, offering information through our IMHA service, Independent Mental Health Advocacy, for people that are either at risk of compulsory treatment, or who may be experiencing compulsory treatment.

And this is important, because often the lawyering bit of it doesn't need to be immediately upfront. So we believe that legal information, as distinct from legal advice or legal advocacy, has a real place in connection with legal services to talk through the sorts of things that people might be wanting to think about in this space, and it's through that work that we have also been able to think about ways of people not becoming so embedded in systems, but also to be looking at what's the path to recovery, rather than what's the path deeper into some of the very expensive systems that we have in Australia.

Necessary, always necessary, for those that are in crisis, but shouldn't be the primary route that people are following when they do begin to get into that sort of more serious difficulty.

MS ABRAMSON: Thank you. Two things about that. We had heard, and of course we've spoken Australia-wide, that one of the issues with the court diversion programs is they're not available in all areas.

MS GLANVILLE: Yes.

MS ABRAMSON: And interested in your comments on that. And the other issue is a broader issue which goes to our report. We're very interested in linking people up with services, so I wondered what your experience was with the diversion programs with people being able to get the mental health support services or psychosocial support services that they needs.

MS GLANVILLE: Yes. So the way in which, certainly in Victoria, but I think probably in most parts of Australia, problem-solving courts or therapeutic jurisprudence has been developed is usually by pilots, and things have been tested. And often when those things work, then they're rolled out, but not always. So we like the model where, where does evidence that says something's working and it's good for individuals - - -

MS ABRAMSON: We like the evidence too.

MS GLANVILLE: I know that, from having read many of your reports, which I find incredibly helpful over time, as well as in the instant. But I think often what happens is that governments may or may not have the resources to actually do that rollout, and it also requires, I think, a cultural shift in the way our justice system works. I think diversion per se, perhaps if you look at police and police responses, often the police response will be to not divert, just because they're focused on perhaps the crime, and the focus is on bringing people to a court.

And so there's lots of parts of the system, including the courts, that need to culturally think about diversion and the way in which that can assist. So I think, when you look at the evaluations of some therapeutic jurisprudence initiatives, ARC is one good example here, as

I said, but the Neighbourhood Justice Centre as well. I think the last time I looked at its most recent evaluation, its breach rate; that is, where people breach the orders they're put on, was 15 per cent less than in any other Magistrates' Court in Victoria.

Now, I'll get back some confirmation of that, and we'll perhaps send that to you. But I'm pretty sure that figure is still about right. And so in and of itself, you would think that it is useful to be able to roll those sort of things out more thoroughly, where in fact they are proving to be beneficial. In terms of service linking, that is one of the roles that IMHA plays for us, the Independent Mental Health Advocacy, which is why I really like it, because I think it moves it away from just what are your legal rights, which of course is fundamental to us and very important in terms of the Mental Health Act in the compulsory treatment context.

But it also looks to what could assist people in terms of being on that journey back to recovery and being able to be included and living a fuller life. I think it is very well known, not only from the evidence to the Victorian Royal Commission, that there are a lot of gaps in the service space, and in fact, we struggle at Legal Aid to really see a system as such, a mental health system, and that's not unique to Victoria. It's just the, I think, the complexity, the growth, the greater understanding in what we understand mental health issues, how they affect people.

And it's also sort of relevant even to our workforces, and the issues that arise perhaps from, if I think more generally, the perhaps lack of attention to bullying in workplaces, or sexual harassment; all these things can lead to certain outcomes for people if they're not dealt with in an appropriate way. And so I think the sort of service linking part is a continuous project for all of us, but I think we need the road map. You know, I think we need to know, what does the endpoint sort of look like, in order to get there, and - so that we can work towards it.

And clearly, the endpoint should be on diversion. It should be on assisting people to be well supported in community, even at the early intervention stage. It should rely on tertiary services like hospitals and prisons, and as a last resort, in my view, and clearly people who need services at crisis point should get them, but we should have a much longer sort of process in terms of people getting to that point, and people being picked up earlier, rather than having to be very, very unwell in order to get any sort of service at all, and clearly, accommodation is a very key part of that. Appropriate housing, as is income security, in some way.

MS ABRAMSON: Thank you. Having asked you all the questions, I'll let my colleagues - - -

PROF WHITEFORD: So just one question. Do you have interface with community treatment orders in Victoria?

MS GLANVILLE: Yes.

PROF WHITEFORD: And how do you think they work for client?

MS GLANVILLE: That is a very good question. I would have to take some advice myself from the people that deal with that to understand that. But my sense is that, in some instances

they're needed, and in some instances they may not be. I think the way I would answer that, from my sort of more systemic, broader knowledge, would be that sometimes we get to that point without having considered other things that might be possible, because of perhaps the lack of linkages to other things.

Because of the, what I would call sort of psychosocial social issues as well that impact on people and perhaps mean they can't function as well. So I'm sure, and I'm not a psychiatrist, and I don't pretend to be, and Legal Aid - I don't think we have any psychiatrists in there, from knowledge, but I'll probably be proven wrong by someone when I go back to work. But our job is to sort of support people with their legal and non-legal issues, and in this way, I think the reality would probably be that for some people, compulsory treatment orders are something that would be useful, and for some they're not.

I think it's probably quite a contested space. One thing we do think is very important that I think we have raised in our submission with you, or if we haven't, we will more thoroughly - we will give you those details - is the importance of consent in these processes, and even with compulsory treatment to be considering what the person themselves would say about whether this is in their best interests, or whether this is something that they feel would be useful, moving away from the best interests terms.

So really engaging with the person themselves. A matter we ran in the Supreme Court which, I think it was last year, found that too often matters had become - were being presented as emergencies and urgent, and so therefore the appropriate engagement of people - of the people who are the subject of a compulsory treatment order was not in place necessarily. And there was not enough consideration of their wishes.

I think sometimes there's a view that if someone's in this state, they can't have a view. Well, of course they can have a view. You have to test these things out, and so we would advocate that's a very important part of putting the user or the person at the centre of the experience, to actually engage with them, and that's why the IMHA service and our legal mental health team aren't very critical in that space as well.

PROF WHITEFORD: Okay. Thank you.

PROF KING: Just one thing, and just maybe covering areas where our team has already got information, but from memory I don't think we have, and that is the different outcomes before - from mental health tribunals, depending on whether there's legal representation or not.

MS GLANVILLE: Yes.

PROF KING: So we've heard - - -

MS ABRAMSON: It's in the report.

PROF KING: Yes, we've heard anecdotal evidence that there is a different outcome. I'm not sure if we've got the statistics, or anyone's actually put that to you.

MS GLANVILLE: So we can provide you with that material. So I think in Victoria, from memory, it's about 15 per cent of people are represented at the mental - in terms of compulsory treatment, and in other jurisdictions, it's quite different. So there's a lot of - that's a hard thing about the Productivity Commission; you're across Australia, and so we really want the best from all around Australia to be captured by your report, the best practice.

And I think what we'll do is we'll send you some material on that. We certainly have done quite a bit of work on that, and that will probably be the most useful.

PROF KING: Sorry, it's more than just the representations, actually. If there's evidence of differing outcomes, systematically different outcomes, but any other legal representation.

MS GLANVILLE: Right.

PROF KING: Sorry, I didn't make myself quite clear.

MS GLANVILLE: I think there probably is, from what I can remember, but I will take that - - -

PROF KING: Fantastic.

MS GLANVILLE: In fact, I'm sure there is. I will take that on notice. Thank you.

PROF KING: Thank you.

MS ABRAMSON: One other thing that I did want to ask you about is when people leave prison. So, one of the things that we observed in our report was there's a lot of churn that people are in for what the system would term as low local offences. So they're sort of there for 12 months to 18 months. And then your observations, if you're able to make them, of the ability to link them with services, particularly if they're not on parole.

So they're released into the community, but under parole, they're will be some supervision, but without parole, how they're - you know, what the situation is with access to services, hence the likelihood that they come into contact again with the criminal justice system.

MS GLANVILLE: I think the widely held view would be that, particularly in relation to housing and supported housing options, and there are - you have a number of people this afternoon who you've asked to give evidence who will be able to speak much more eloquently than I can on this, but as someone who's always had an interest in housing, because it is so fundamental to people's wellbeing and ability to be included in life, that is a very fundamental aspect of where people stay and live post any prison period.

And we do know that sometimes, very, very sadly, people are in prison because there is no other place for them to be, and we've had several matters in relation to the NDIS where this has been the case. So it really requires governments and communities generally to be thinking of how do we have the stepped up and stepped down options that are going to support people. And of course, housing, I think, is the most basic thing, to be honest with

you. I think if you've got somewhere to stay, that's a big plus in filling a level of stability in your life, and then surrounding that should be the other services that people need.

But I would say housing is probably one of the most critical, in terms of people's journey back into being able to contribute more thoroughly to the community and the society that they live in.

MS ABRAMSON: Thank you. Can I ask one final question, if I may, and I happen to be a lawyer, which is why (indistinct).

MS GLANVILLE: Good.

MS ABRAMSON: If that was not obvious before. Just the civil side of your work. Like we focused on the criminal side in our conversation this morning, but the evidence that we found was that people with mental ill-health were likely to have more issues in the civil side. You touched on housing, so your work in that area would be interesting to us.

MS GLANVILLE: Yes, and that's very much the case. I suppose I'd say housing, but fines as well.

MS ABRAMSON: Which you touched on (indistinct).

MS GLANVILLE: Yes. The NDIS. We have quite a large practice now in relation to supporting people as they go through that process. I should say, Victoria Legal Aid is a very big supporter of the National Disability Insurance Scheme. We want it to be as good as it can be. We see many - well, we don't see the many fantastic examples of it, but I know they are out there. What we see is, often when people are in strife and difficulty with it, but that is a critical area.

Immigration matters; we see issues that relate mental health issues, and I suppose really too in sort of the employment law, and particularly the discrimination space as well. I think this is a very important area to look, and goes to the points you've made in your report about needing that more systems wide lens to thinking about productivity issues in relation to people with mental health issues in all the intersections they have with different systems. So, if you were interested in that, we could make a little summary for you, of what we're perhaps seeing in each of those areas.

MS ABRAMSON: That would be very useful.

MS GLANVILLE: Some of might be qualitative, some of might be - some will be quantitative, some will be qualitative, but to give you a bit of a flavour of that, and we are well placed to do that, because we are in every Magistrates' Court. We're down at VCAT. We're in public hospitals. We'd like to probably be in private hospitals as well, but not funded for that. And it will give you a sense at both the commonwealth and the state level the sorts of matters that we see where there's a real intersection with people's mental health experiences and their mental health issues.

MS ABRAMSON: Thank you.

PROF KING: Okay, thank you. Thank you.

MS GLANVILLE: Thank you very much.

PROF KING: Thank you so much. Perhaps if we just take now a break for morning tea. Perhaps about 20 minutes. Let's start again just a little bit before a quarter to.

SHORT ADJOURNMENT

PROF KING: Let's recommence the hearing, and there is something - - -

MS ABRAMSON: Are you right, Stephen?

PROF KING: Yes. I'm just seeing if there's anything else that I need to mention. Just for those of you who have joined us since this morning, just a couple of things. Obviously, phones on silent. The microphones are for the transcript. They're not for amplification, so I hope you're able to hear. It is being live streamed on YouTube, so please be aware of that, and if you - if any of the participants do not wish to be visible or audible online, then you need to make that clear to our team members as soon as possible.

If there are members of the press here, please let our team members know. And that will probably do it before we recommence. So, the first present, or first participant after morning tea; Robyn Hunter, please. And if you could name, affiliation, for the transcript, and any opening comments you'd like to make.

MS HUNTER: Thank you. My name is Robyn Hunter. I'm the Chief Executive Officer of Mind Australia. Mind Australia is one of the country's leading community managed specialised mental health service providers. We have been supporting people dealing with the day-to-day impacts of severe and enduring mental illness, as well as their families, friends and carers, for over 40 years.

Our 900 staff deliver services in our own centres, and outreach programs, and residential services, and in step up and step down services in partnership with clinical agencies around Australia. In the last financial year, Mind provided over 400,000 hours of recovery focused, person-centred support services to over 9,000 people, including residential rehabilitation, personalised support, youth services, family and carer services, care coordination, and step up/step down services.

Mind welcomes the Productivity Commission's inquiry and believes it is a major opportunity to re-evaluate Australia's mental health policy and service system beyond the historical framing of illness and medical interventions. We welcome the draft report from the Productivity Commission, and as we read through, analyse and consult with our staff on the 1,238 pages of the report, our initial thoughts are that it's heading in the right direction, and offers welcome reforms to improve the mental health system.

We offer these further insights at this hearing across three areas. Workforce, housing, and carer inclusion, to ensure the final recommendations remedy inequities in social and economic determinants in equal measure to those that deal with the treatment and management of the symptoms of mental illness. We will also be lodging a follow-up submission by 23 January, which will expand upon these points in greater detail.

Community mental health workforce. We welcome the recommendation to strengthen the consumer and carer peer workforce, and see this as a positive step forward in the provision of recovery oriented mental health care. However, we see a significant gap in the report in relation to the community mental health workforce. The community mental health workforce, which makes up the bulk of Mind's 900 staff, are facing significant challenges, and we, as an employer, are experiencing an uphill battle to attract and retain our staff. This must be central to the development of a new workforce strategy.

We understand from some of your Friday hearings with Mental Health Australia and Mental Health Carers Australia that the Commissioners are having difficulty in understanding the demarcation between acute, sub-acute, and psychosocial, and that competing language is confusing. Psychosocial community mental health supports give greater emphasis to addressing social determinants and rehabilitation needs. There are specific roles for consumer and carer peer workers.

We seem to be fighting for community mental health professionals who are skilled in recovery oriented practice and support to provide family focused and care inclusive care, to be considered as a critical component for complex care, high-intensity care, and moderate-intensity care. Our staff are facing great uncertainty. The current configuration of commissioning models, short-term contracts, and delays in contracting and short notice periods for contracting end dates, is combining to create uncertainty for workers, and this is evident in rising sick leave, turnover rates, and difficulties attracting, recruiting, and retaining staff.

These issues have been further exacerbated by the NDIS. Our experience indicates that the low price point for psychosocial community mental health signals this workforce is undervalued. In the regulated pricing regime of the NDIS, our experience of the transactional nature of funding, the low pricing of supports, and no allowance for provider travel, has provided a significant challenge to the provision of outreach recovery oriented practice.

With retention, Mind has bucked the tide towards a casualised workforce, and has demonstrated this commitment to our prized, dedicated, and experienced workforce by providing ongoing employment contracts. This is to retain our workforce. Their pay is grandfathered at a higher price point to reflect their qualifications, years of experience under (indistinct) and practice wisdom. This costing millions from Mind's financial reserves. We would like to work with the Productivity Commission further to develop a community mental health workforce strategy that addresses our concerns.

What is working is a team-based approach, including consumer and carer peer workers, community mental health practitioners with recovery oriented practice supervision and training. Further, in Queensland we are investing in upskilling our workforce in complexity

to reflect the increasing acuity and complexity our clients are presenting to us, to support them on their recovery journey to live contributing lives.

Housing. We contended quite clearly in our submission that supported housing needs to be viewed as a health response. It is pleasing the Commissioners have recognised this with recommendations that acknowledge that suitable housing is a first step in promoting long-term recovery for people experiencing mental illness. We welcome focus on improving SDA, Specialist Disability Accommodation, for people with psychosocial disability, especially in regard to lifting restrictions on the number of people who can reside in SDA.

We would ask the PC to further investigate the SDA funding eligibility for people with primary psychosocial disability, and the lack of investment in SDA for people with psychosocial disability. As we mentioned in our submission, Mind is partnering with AHURI to develop a clearer understanding of the relationships between housing and mental health pathways of people with mental health issues, in order to identify potential points of practical intervention and key issues for system improvement. This research will be published in February 2020, and we would be very happy to share this with the Productivity Commission.

Carers. Mind is of the firm belief that carers and family involvement need to be embedded through the mental health system, and their role strongly supported in the workplace. We welcome the Commission's chapter on carer and families, and the recommendations to improve the carer payment and carer allowance, especially in relation to the 25 hour rule, but hope the inclusion of this cohort can be expanded in the final report to be embedded across the whole mental health system.

Mind and other organisations developed the Practical Guide for Working With Carers and People with a Mental Illness, and we think the PC should consider ways to mandate the six partnership standards contained in this guide. The guide partnership standards were developed through co-design, integrates consumer and carer outcomes, providing a tried and tested approach.

Carer inclusive workplace practices also need greater consideration. There is scope for government departments, unions, and the National Mental Health Commission to partner on developing a framework for carer inclusive workplace practices. We look forward to contributing to specific points raised in the draft report in our final submission.

And finally, the social and emotional model of mental health. The final report must provide a greater focus on the social and emotional model of mental health which strongly considers that social and economic determinants, and the relational aspects of mental health, are crucial to recovery. A social and emotional model of mental health would place a person at the centre of their supports with a greater focus on the wellbeing of their most important interpersonal, day-to-day relationships.

While this has received attention in the draft report, we still think that it has too much of a focus on the medical model of mental health, and we require a clear vision for what we want our mental health system to look like in the future. For Mind, this is a recovery oriented

model that clearly places the treatment or management of symptoms of mental illness alongside interventions that deal with the impacts of those systems on people's lives.

PROF KING: Thank you. Just a couple of clarifying things before I pass over to my colleagues. Yes, we love the joint work you're doing with AHURI. When that's available, we'd be very grateful if that could be sent in. Two clarifying things. Firstly, when discussing the carer allowance, you said you'd like to see some - I'm going to paraphrase; my apologies. Something like, 'this embedded over the whole mental health system.' Were you talking about things like carer inclusive workplace practices, or? Okay. So I now understand. So the comments that were following on was - were referring to that; that's fine.

And just the last one, because this is again something that's troubled me a number of times. At the end, you mentioned the social and emotional model of mental health versus the medical model.

MS HUNTER: Yes.

PROF KING: And I guess, as a non-clinician, and someone who comes from outside the sector, I do find that juxtaposition slightly odd, in that what we tried to do, and perhaps we could have communicated it better in our draft report, but what we tried to do is make it very clear that, well, you can't have one without the other. That you can't have success in the medical model unless you've got things like appropriate housing and supports and community.

But nor can you say, well, let's ignore the medical side of this and just have appropriate supports and community without having the clinical side and clinical support. And we know the issues that arise when people don't seek appropriate clinical support. So could I just get you to expand? Are you saying that it's one or the other?

MS HUNTER: Definitely not.

PROF KING: Or are we wrong in what we've tried to do?

MS HUNTER: No, no. I think it's reflecting a desire for a greater balance. So I think that it's - Mind does a lot of very important partnership work with clinical agencies in the sub-acute or step up/step down space, and I think that's a lovely example of where you actually have roles to play, and they need to be stitched together in a partnership so that you can actually really work on all elements.

I know there's some confusion in the language between community mental health and that that's provided by health services, versus that outside of that. And my simple explanation of that is, in the medical model, it's around managing and containing the symptoms of mental health, whereas the work that we do in the psychosocial space is actually trying to move towards rehabilitation, against particularly goals that are taking into account their social and emotional wellbeing.

PROF KING: Again, sorry, I'll pass you to my colleagues in a second. But again, is that really - is that saying - - -

MS HUNTER: It's not one without the other.

PROF KING: Hopefully a clinical system is focused on rehabilitation and recovery. So is it saying that there are different roles because of the different organisations, or is it saying, well really, we need to get more of a recovery focus into the clinical services? I guess, perhaps naively, I'm less worried about if it's sub-acute that's provided through hospital funding, or is it community-based services. What I care about is, are we getting the outcomes that the consumers want and require. So again, I have some trouble with this differentiation that, as an outsider, seems artificial.

MS HUNTER: My attempt to explain this is that people are presenting into the acute health system much more complex and acutely unwell than ever before, and they're being discharged from the acute system at a higher level of acuity than they were previously. So I really think that that's what hindering, from my acute colleagues, their ability to adopt this sort of practice. There are, you know, really quite severe pressures at the acute end for them to be able to adopt that approach.

PROF KING: But it's more the pressures in the system, and perhaps the incentives or the constraints within both clinical and the community provision of mental health services, rather than different objectives, as such.

MS HUNTER: Yes. Look, I think, again, coming back to your point; they're not one against the other. They're trying to do different, very important objectives, and they need to be done in a linked up way, a joined up way.

MS ABRAMSON: Ms Hunter, I just want to follow up a bit on what Stephen's been talking about, and come to a direct point. The way that the report is crafted, it's got the separate sections. We've got one that deals with the medical system, psychosocial supports. Bearing in mind what you've said, what type of recommendations, or the way in which we frame our conversation, were you interested in seeing us develop?

MS HUNTER: I think it's really to try and reflect for the community mental health workforce an appreciation of the specialism in the practice wisdom that they have through working with people. I think one of the greatest concerns we have is that the - I referred to it in the NDIS, but it is happening elsewhere - that the price point for the workforce is actually quite low, and it's not reflecting the training and supervision that is required to support people, particularly as people are coming through and presenting to our services more complex and more unwell than previously.

MS ABRAMSON: I mean, we have said - and I understand what you're saying - we have said that, as we also do, that the contract periods are too short, and I have to say, this is a consistent refrain of the Productivity Commission. But in terms of the workforce itself, those are, of course, broader issues about value for work and the nature of work. So have you got specific recommendations that you're asking of us in that space?

MS HUNTER: Look, I'll take that on notice - - -

MS ABRAMSON: Absolutely.

MS HUNTER: - - - and make sure that we do come back with some. I think one of the things that Mind is doing is really promoting undergraduate student placements, and really that's where people come in and develop a spark of interest and then, hopefully, a career commitment to working in the space. And so that's one of the things that I think was brought up earlier as well, so that it is seen to be a really fulfilling career opportunity, and that there is opportunities for career progression is also important. It's often around the job insecurity, as opposed to the actual wage.

But as an organisation, we're just finding that the - the specialism, and I'm trying to be careful in my terminology there, is well recognised and appreciated and valued for the work that is being done.

MS ABRAMSON: I might ask that, perhaps in your submission, you could turn your mind to that, and also, we've talked a bit this morning about stigma, so if you also had some ideas in that space, they would be very welcome. Thank you.

MS HUNTER: Okay. Thank you.

PROF WHITEFORD: So, just going back to the workforce issue. So the community mental health workforce that you're referring to, can you just give some idea of the - I know you've already touched on this several times, the types of people who would be - would make up that workforce? The backgrounds?

MS HUNTER: Yes, and I will put more specific data through. We haven't actually captured that routinely beforehand. What we have found in our experience of the NDIS is that our community mental health professional workforce, many of them have undergraduate qualifications in psychology, social work, OT, youth workers, and that through that - and I think this is an unintended consequence of the NDIS - but because the price point for allied health professionals is higher, by encouraging our workforce to actually become APRA registered, we can actually bill at a higher rate.

And I think that's regrettable. I don't think that we should be having those sorts of unintended incentives. The workforce is one that - for example, I'm thinking of a couple of team members who came through as students, and we've been fortunate to employ them as new grads and they're working in our supported independent living services as part of their career trajectory. Who knows where they'll up with their careers, but it really is making sure that they actually get an understanding of the different ways of supporting people with severe and enduring mental ill-health in their recovery process.

PROF WHITEFORD: Sorry, can I ask a follow up question then? So, if they're employed in one of your services and they have a psychology degree, or a social work or occupational therapy degree, are their pay points different to if they were working in a clinical service?

MS HUNTER: So, when they're employed by us, they're employed as community mental health practitioners, so they're employed under the SCHADS awards. If they were employed in a clinical mental health service, more likely they would be employed as a OT or a psych.

PROF WHITEFORD: And that means?

MS HUNTER: Different pay.

PROF WHITEFORD: And does that mean that you're likely to lose them to the clinical services?

MS HUNTER: Yes, we don't have a lot of - we haven't experienced that, to my knowledge.

PROF WHITEFORD: Okay.

MS ABRAMSON: Can I ask you, on an entirely different track, we've had a number of people comment that they would like to see more done in the CALD space. So I'm really interested, and we've got some information requests in our report, because we'd really like to know, what would that look like? What are the type of communities that we should be looking at, because there is so many multicultural groups in Australia. So thoughts on that, even in your submission, would be very welcome.

MS HUNTER: Yes, I'll take that on notice, but definitely come back to you.

PROF KING: Okay. The only other one from me was, you also mentioned peer workers and the peer workforce. We've got a number of recommendations in there, but as you mentioned a workforce strategy, we'd be very keen to understand if you think the sort of recommendations we've got have gone far enough, or if there's other things we need to recommend about getting peer workers. So right through the whole mental health system. We'd be very interested in hearing of that.

MS HUNTER: Certainly.

PROF KING: And, of course, ways to do it.

MS HUNTER: Yes. Will do.

MS ABRAMSON: Thank you.

PROF KING: Thank you.

MS HUNTER: Thank you.

PROF WHITEFORD: Thank you.

PROF KING: Next, we have Dr Peter Kent.

DR KENT: Commissioners, I do have some sketches and diagrams that might help understand what I'm talking about.

MS ABRAMSON: Thank you.

DR KENT: I'll just leave those here, if I might.

PROF KING: Thank you. And if you could state your name and affiliation for the record, and then any opening comments that you'd like to make.

DR KENT: Thank you. Well, my name is Peter Kent. My affiliation is I'm the founder of a new charity, and it's the process of being established, called Restart Health Services, and that is oriented to the needs of people with severe mental illness and comorbid, overweight and obesity as its core objective. I'm going to talk a little at the personal level, because there's a member of my family that's had psychosis and schizophrenia, and then more at the policy level. So perhaps if I start at the personal level.

My youngest son, who's now 31, and he knows I'm talking here, I've cleared that with him. Twelve years ago, in 2007, he was flying along in first-year university. He had been captain of sports at school, a healthy, fit young man. In his first semester, he was averaging distinctions in his grades in a combined Commerce/Engineering course, and then in the second semester, he fell into a first episode psychosis, and subsequently was diagnosed with schizophrenia.

So for the last 12 years, his mother and I have been his carers, and I have mostly involved in that world simply as a parent with a son who has a severe mental illness, and dealing with psychiatrists, and the normal things you do along the way. One of the things that's happened is that his physical weight has ballooned out. You'd be aware, of course, that the antipsychotic medication has clearly increased the appetite, and that's one of the factors in that.

He was about 72 kilograms when he fell into psychosis. A fit, slim, young man. Now he's about 105 or 106. So his weight's gone up 50 per cent in 12 years, and that creeps up on you. I mean, it's three kilograms a year. We didn't notice it for a while. When it got to 90, hey, you're getting a bit heavy. Do you think you cut it back? And we have managed to stop or, or stop it increasing at around about his current level of 105 kilos, and I'll explain why in a minute.

But what we found he was doing, is that we could sit down and have an evening meal together, and then an hour later he'd say, I'm hungry, I'm going out. And he's off to one of the fast food chains and buys food, and sometimes not just the food, but a family pack. I mean, the hunger is really driving. He wants to bring his weight down. He's trying to do that; he struggles. We've said to him - we've tried multiple things, of course - but we've said, look, if you're going to get a burger, don't get the fries and don't get the soft drinks. And he's probably compliant about 70 or 80 per cent with that.

And he therefore has plateaued off his weight, but he still finds it very hard to bring it down. We are aware, indeed acutely aware, that the - there's foreshortening of life for such people, as you would know, that - usually by 10 to 20 years is the common sort of range, and they're subject to early death, mostly from the physical comorbidities, which generate the cardiovascular problems, the Type 2 diabetes and so on.

So that's in the back of my mind here, and when I heard about your Commission earlier this year, I began to shift gears and think, well, let's not just look at this at a personal level. What about the national policy level? So I'm going to talk a little bit about that too, and where I've come from. I'm going to talk about the needs and delve into the problems a little bit, but I also think there's some potential solutions that aren't invoked yet here in Australia, which can help these people, and indeed have a small impact on suicide reduction. So I'll to that in a few minutes.

So I'm focusing on the people with severe mental illness, and by that, I mean schizophrenia, schizoaffective disorder, bipolar and severe depression as the core group, and the comorbid, overweight and obesity. And if you want to have a look at that first diagram, it's just - - -

PROF KING: Because of the way the hearings are done, Dr Kent, we may need to deal with this as a submission, rather than running through it here, because of course, the transcript can't see diagrams.

DR KENT: No.

PROF KING: So rather than spending time on this - I understand that you may want to draw our attention to some diagrams, but please do it in a very minimal way.

DR KENT: Okay.

PROF KING: Because otherwise, we obviously lose, not just the transcript, but also 100 or so people who are viewing this online.

DR KENT: Yes, okay. All right. I shall do that. All right. What I want to do is to mention the problem to start with, and then that's to show the severity of it, and then move on to what we can do about it.

MS ABRAMSON: But Dr Kent, did you want us to take this material as a formal submission to the Inquiry?

DR KENT: Sorry, I beg your pardon?

MS ABRAMSON: Do you want this to be a formal submission to the Inquiry?

DR KENT: Yes, I think, so. Thank you.

MS ABRAMSON: Yes, thank you.

PROF KING: Sorry, I hadn't assumed that. My apologies. Yes.

DR KENT: Yes. So starting with Australia's obesity, we have - the Australian Bureau of Stats shows that it's going up and up and up. We now have two-thirds of the population, or 67 per cent as of 17/18, who are either overweight or obese, and that is about roughly half overweight, and roughly half obese, and that's going up. So that's a background fact that affects all of these people with mental illness.

And of course, those who have mental illness and are being treated for it, have - as I noted in your report, there's other factors apart from the background factors. There's the medication. There's the low income, which gives a propensity to buying cheap foods. There's a lack of exercise, there's a lack of nutritional knowledge, there's a lack of cooking skills, and so on, all in the mix contributing to this total problem. So it's well known that, as I have touched on before, that we have these problems of early death resulting from this.

When we look at this in a relationship context, overweight tends to drive obesity, and there's quite a lot in the literature says there's a relation - a two-way relationship between obesity and depression, or mood disorders. So if people are overweight, their self-image goes down, and other things go down, so they tend to become depressed. And the other way people are depressed, so they don't exercise, they get junk food and they become overweight. So you've got that two-way relationship there.

And with these people with mood disorders, or with depression in particular, the ABS stats shows that we have about 44 per cent of them, when they analyse the causes of suicide, the biggest single cause is depression, in about - it's your report too; 44 per cent or so there. So links between food, eating practices, obesity, mood, and suicide. There's a correlation all the way through there.

MS ABRAMSON: Dr Kent, I apologise for interrupting you, but I'm particularly interested in your solutions and the recommendations that you make. Is there anything in the material that you're presenting to us now about the statistics where you feel that perhaps the Commission has not understood the extent of the problem?

DR KENT: Yes, I think there is one bit, which I'll come to in a minute. Can I draw your attention to just one thing here, and that's some very good work out of Melbourne here, with the Food and Mood Centre, led by Felice Jacka, on changing the diet of people who had poor diet resulted in a drop in depression by about 30 per cent. It was a big factor there, and that's been verified overseas with other studies. So this is the beginning of this nutritional psychiatry field where changing diets is starting to impact on outcomes.

Now, this is the bit that I think perhaps you haven't got in your report. On your website, you've made the claim that suicides, or years of potential life lost and suicides outweigh those of road accidents, and you've got the things to show that. Just when I take that a little bit further and look at the population with severe mental illness, and this - your figure is 775,000, broken up between episodic and complex and so on, but nearly 800,000. And we can say that, conservatively, 75 per cent of those are overweight or obese, because we're building on a population base of 67 per cent.

When we break that out, it means we've got nearly 600,000 people who both have severe mental illness and overweight or obesity. And when you look at the years of life lost, potential life lost from that group across the entire population, it multiplies out to about 8.7 million years of potential life lost. So that's over that population. So if we assume that the population, say mental illness onsets at the age of 20, and they live to about 67, because that's the average age they will live to, that's a population age range of 47 years. So, in essence, that population changes once every 47 years.

And if we divide through - the figures are in that report there - it means that, on a yearly basis, the years of potential life lost from severe mental illness and comorbid, overweight obesity are about 185,000 years of life lost per year, and that is more than the combination of suicides and road accidents combined. And the reason I'm mentioning that is just to mention this and put it into context, just how significant it actually is for these people.

So when we come to address this problem; what can we do about it, your report says, I think, on p.6, 'There's substantial underinvestment in early prevention.', and I would agree with that. I think there's also substantial underinvestment in facilities and services for these people with severe mental illness, and part of that may be that it's just been in the too hard basket. What can we do about it? If we do spend money, what are we going to do?

I want to talk about the introduction in Australia of residential therapeutic farms, right, that to date don't exist here. There are a couple of farms for drug and alcohol rehab, and so on, but they don't really exist here, and I was looking through this possibility, because when I go back to my son, and you want to help him to reduce his weight, when you're here, you can go down and buy fast food anywhere.

If we take people like this who may be either at home or in non-acute beds, depending on where they are on the spectrum of illness, if they're in a farm, they can't duck down the street and buy cigarettes. They can't duck down the street and buy burgers. The only source of food is the farm dining room. So you have some range of control over people's diets. So there are farms of this type in America, and I've just been on a study tour last month of four of these farms, and they've been very, very helpful. They have evolved over decades, and they have a lot of accumulative experience.

They're doing all the things that we do in some of our post-acute services around Melbourne, around Australia, but they're doing it in a natural environment. And immediately, once someone moves to the farm, they're in a relaxed, rural space, rather than in a high-pressure urban space. They are able to interact with animals. Some of them use animal therapy, so dealing the donkeys and the horses and so on. Some people, some of the residents, relate to these animals before they can relate to people. There's lots of ways to set up therapeutic processes there.

I've given reference here to the four farms that I visited. You can look at their websites, and there's far more in there than I can possibly cover this morning, so I'll jump over that. But they're all excellent places. But a well-structured therapeutic farm offers the full range of clinical services, psychosocial services, community-based services, in a safe, supportive environment. Now, if we're going to set this up in Australia, the first thing you start with is safety.

Now, when people come into these farms, they might have been just discharged from an acute hospital, or they might have avoided the acute hospital and gone straight to the farm, because they're at that level of severity. And people who are unstable in this way, they watch them very closely. Usually on these farms, they have group housing dotted around, which might be eight or 10 people in a group house, with a resident adviser in every place. But the ones who come in initially, for the first 30 days or so, they're in a house, if you like, attached

to the administrative area, and they are watched, unobtrusively, but there's observation of these people every 15 minutes. So it's 24/7 coverage. Even during the night, there's someone popping their head into their bedroom to see they're okay. It's all designed - there's no hanging points, and so on.

But they are well of the possibility of suicide with this population, and I think your report or other says that the risk is about 100 times higher than the normal population with this group. So you really do have to watch them very closely. Once their stabilised, it drops down to about every hour, you know, where somebody is - so there's a lot of resources there. One of the things they do on the farms is to say, during the induction period, well what are your wellness goals? And they might be reduction of clinical symptoms, improved self-esteem, improved social skills, improved diet and cooking skills, and a lot of them asking for that; an understanding of nutrition.

Increased personal organisation and life skills, loss of weight for those who need it, becoming a non-smoker for those that want to go down that track, improved overall health, and improved readiness for work. They're the sort of objectives that people tie into here. So they're wellness goals. The sort of activities that they engage in day-to-day, there's a much wider range of options than there is in any city-based activity.

One of the farms, I stayed there for a week, and I got involved in the grassroots work programs day-to-day, and they have team leaders in each area, and the team leaders might be someone who's a farm man who's trained in agricultural matters, but they also have to be selected for their quality of personal empathy, and some degree of training in the psychological or psychiatric issues. And there's a two-way flow of information all the time.

At the top of the clinical pyramid is the psychiatrist, and then there's social workers and psychologists in that mix, and information flows down and it may be that the farm guy's told, look, Harry's been unstable, could you keep an eye on him? And equally, it flows up. He reports back. So there's an end-to-end communication flow there. But people may be involved in feeding farm animals, planting the harvesting crops, repairing fences or maintenance work. They're assisting the chef in the kitchen and learning cooking skills. They can be serving meals.

Working in the farm laundry. Cleaning, weeding gardens, harvesting apples and making cider. Working in the woodwork shop. Working in the farm bakery, and so on. There's a whole lot of things you're going to get people engaged on, and behind this is the strategy that we don't want people sitting around. They are finding that you've got to get people up off their butt, basically, and out doing some kind of work during the day, because it's setting a pattern for an organised lifestyle.

PROF KING: Just keeping my eye on the clock, because obviously we need to be fair to all speakers.

DR KENT: All right.

PROF KING: We've got the submission here, which you're running through. Could we actually jump forward to p.23 of your submission, which is really the recommendations.

DR KENT: Yes, yes.

PROF KING: So, we've got the material that you've provided on the benefits of the restart farms. You've got three recommendations here. Perhaps if you could talk briefly through those.

DR KENT: All right, okay. Well, if we're going to - can I just say briefly, at p.22, if we're going to set things up, we've had an architect doing some sketches of what it might be. Broadly speaking, to set a facility up for 80 residents, it is more cost-effective to have a large than a small. It's about \$20m. A couple of million dollars to buy the land, \$20m ball park to construct the facilities, and another \$3m to - for initial staffing. You've got to set up all your systems, all your processes, your training and so on, before you open the doors.

So we think about \$25m to get one of these up and running, and the operating costs are based on staff ratios. You've got to have about a 1:1 staff ratio, because if you don't, you can't provide the services. You can cut that back. Now this is going to work out to about \$100,000 per head in one of these places, but it's a little bit less than prisons, which I think are about 110,000 a year, and a lot less than acute hospitals, which might be 400,000 a year. So, coming on to the recommendations, we're saying that we believe it is worthwhile setting up such farms in Australia, and that's why I'm working on this charity to get things going.

Establish an appropriate funding model. Maybe the Commonwealth could provide funds, capital funds, to develop say two farms initially as pilot farms, one in Victoria, one in NSW, and eventually up to about 12 or 14 farms to get of the order of 1,000 beds here. I noticed in your report there was a shortage of post-acute beds, or non-acute beds, et cetera. This is one way to fill that gap, and we could add one extra farm per annum. But I don't know exactly the right funding mix here. That's far more your domain than mine.

MS ABRAMSON: Dr Kent, could I ask you, how are they funded in America?

DR KENT: Look, it's totally different. They have to be mostly private paid, because the government doesn't kick in the money, basically.

MS ABRAMSON: So they're philanthropic funding?

DR KENT: Yes. Yes, they do get that, and it's the reason they haven't ballooned out into a large number. But there's a cut-off that only five per cent of the population can afford to go there, because their fees are 300 to US\$500 a day. So you're paying \$10,000 a month or more, depending on their own staff ratios. They do extensive fundraising and philanthropic work, and thereby they can give people 20, 30 per cent remission on fees, depending how the fundraising's going. But that's one of their ongoing issues.

But if we have a different health system here, we may be able to get the bulk of the costs covered by either some sort of government grants or funding, and then philanthropy would play a smaller but important role.

PROF KING: Could I follow up on that? For us to make a recommendation such as the one that you've got here - I agree completely, but the \$100,000 per person per year is a lot less than - because it's about \$120,000 last time I looked.

DR KENT: Okay.

PROF KING: It happens to be an area I've worked in, and obviously much less than acute hospitals. But that's not really the right comparison.

DR KENT: Okay.

PROF KING: The comparison is the cost-effectiveness of the Restart farm approach versus the cost-effect - cost-effectiveness, I mean. How effective are the facilities, the residential services, essentially, is what they are. How effective are the residential services at meeting the outcomes for the consumers versus the cost.

DR KENT: Yes, yes, yes.

PROF KING: So that's what I mean by cost-effectiveness here.

DR KENT: I can respond on that if you'd like.

PROF KING: Please. Yes, and particularly if there's been an evaluation. You mention the Gould farm here, and you mention its absolute outcomes, but you don't mention relative outcomes compared to alternative residential services, in-community residential services.

DR KENT: No. I haven't had a look - had a chance to do that comparison yet. But they do a lot of work on measuring outcomes. They use a number of psychiatric measures like the GAF, which I think is the Global Assessment of Functioning, and other ones. And there's no way someone goes from very sick to very well, that's not in the question. But some of them - they all report - get outcomes. They usually have universities engaged to evaluate these with proper statistics, you know, and psychologists working on it, professionally done, and it's on - a lot of it's on their website.

If they get someone move in - coming in with a GAF score of 45, which means pretty low functioning, and go out at 60, that's - in these terms, that's a significant gain. When they move out to transition out - as they transition out, there's a step down model - they can improve after that as well. But that means they have improved their social skills, they've - their symptoms have abated somewhat. It means that their personal life is better organised. It means they're more work ready.

So there's the qualitative outcomes, and they feel better in themselves, by the way, too. And part of the evaluation is, what do the families say? And the families are pretty enthusiastic about it, so much so that some of them come back and say, look, we're going to give you a \$5m donation. I mean, that kind of thing speaks for itself. So they have the formal and the informal measures of outcomes, and yes.

MS ABRAMSON: Do they deal with substance use disorders as well? (Indistinct).

DR KENT: Yes, some of them do. Yes, some of them do, and they don't all do that. I'm thinking here in Australia, that is something we would need to add on subsequently. Initially, I think there's enough to focus on just to get things going, right. But that, no doubt, would arise and have to be addressed. Yes.

PROF KING: Good. Okay. Thank you very much for that. If, as I said, our recommendation at the moment is quite deliberately general in the sense of there needs to be more residential services, particularly for people found with severe - when they're moving out of hospital, moving out of hospital community-based services in - hospital-based services into community-based services, and we deliberately haven't, in a sense, approached it the way that you say, well, I'd like a recommendation on Restart farms.

For us to go that extra step and say, Restart farms as a specific recommendation, we do need that evidence to show that, not just that they're reaching outcomes, but they're reaching better outcomes than an alternative.

DR KENT: Okay.

PROF KING: So we'll look up, obviously, the Gould Farm material that you've mentioned to us. Again, if there's any other material that you come across that is able to answer that question, then that would be extraordinarily helpful.

DR KENT: Okay. I'll look into that, and perhaps I can send it to you if I - - -

PROF KING: If you could.

DR KENT: - - - if I find it.

PROF KING: Absolutely.

DR KENT: Yes, all right. Thank you very much.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you very much.

PROF KING: And I will look at Miriam. You need a copy. This is a formal submission, as an electronic copy. Would you be able to - yes. If you could just liaise with Dr Kent so that we can get an electronic copy.

MS ABRAMSON: It's very organised.

PROF KING: Next, we have Elizabeth - try again. Sorry. Grab some water, I think. Elizabeth Yared and Fiona Costolloe, from Launch Housing. And again, whilst I've already said it, if you would be able to state your names and affiliation for the transcript, and then if you have any opening comments you'd like to make.

MS COSTOLLOE: Thank you. So, hello. My name is Fiona Costolloe. I work at Launch Housing as a group manager of our permanent support programs.

MS YARED: My name is Elizabeth Yared. I'm an intensive case manager in a program called Complex Care. So I work with people who've been chronically homeless, with complex support needs, including severe mental illness.

MS COSTOLLOE: So I guess we'll just perhaps start with a brief overview of Launch Housing. Launch Housing is an organisation providing support and accommodation to people who are homeless or experiencing homelessness, or who are at risk of homelessness in metropolitan Melbourne. Launch has about 14 sites and approximately 400 staff members, and we work closely with people in the community to support their transition into affordable, secure, safe housing, and to work with them during that time, in a lot of cases, around their mental health support needs.

We work quite closely with a lot of different parts of the mental health service sector, so whether that be acute clinical settings, clinical support services, or community mental health support providers, GPs, and the like. And then we also have a number of programs that have a specific mental health focus, where we're working very specifically to address the mental health needs of that particular person who's homeless, or at risk of homelessness. Go for it, Liz.

MS YARED: I suppose what I can offer is what the interactions between housing and mental health actually look like on the ground, and then I'm quite happy to take questions on the draft recommendations that you've made. I suppose, in terms of people with mental illness interacting with the housing system, and mental health services interacting with the housing system, I think any recommendations really need to take into account the severe shortage of social housing. It's very difficult to do something like formalise a policy of no exits into homelessness from institutions without the actual resource to back that up.

I understand that that's beyond the scope of your inquiry to fix the housing system. It is a challenge though that perhaps any policies like that would not be effective if we were not to address that actual resource that's needed. If you are in acute mental health, if you are, say for example, in (indistinct) unit, the discharge plan for you is likely to look like either going straight to an entry point - Launch has several entry points where you can present.

It's like a shopfront style service. It might look like the hospital arranging a rooming house, which is unfortunately another form of homelessness, and particularly unideal for people experiencing severe mental illness. Or it may look like short-term accommodation, either crisis accommodation or emergency accommodation in a motel until the most likely outcome, which will again be a rooming house. So I think that that stock issue, while I understand is a bit beyond the scope of your Inquiry, does really need to be addressed if we're going to address people's mental health.

It's very difficult for people to start their recovery journey if they don't have a stable, secure and affordable place to live. And then I think the other side of that is when we have been able to find people suitable accommodation, the experiences of people who have been homeless interacting with the mental health system can be quite challenging. My team sees a

few sort of different key issues. I think the availability of ongoing clinical case management is quite limited, and it can be quite difficult to access that resource.

The type of support is very inconsistent beyond different catchment areas. So you may have assertive outreach and outreach case management in certain areas. Somebody transitions to a different area. We may have found them housing, which is great. There may not be the equivalent support commensurate to their needs, so it may - might be a sort of an appointment based, clinic based service, whereas previously they were receiving an assertive outreach service, which they really required.

And then I think the rigidity of the catchment based system, I think it's difficult to completely abolish that. I can't really see a system operating without catchments, but the transition points are particularly poor. People are closed very quickly, and it takes a long time for them to be picked up by another service. So I think perhaps the Productivity Commission could look at those transition points, and how different catchments are working with each other.

And then I think it's been touched on by Mind Australia, from what I heard briefly coming in, the transition of community mental health to the NDIS has had an impact on our client group. It was previously a low barrier to access. People who were not able to access other types of mental health support, like clinical case management, or attending a GP, were able to receive that recovery focused community mental health support. That's now with the NDIS, which has quite a high barrier to access, and multiple barriers to sort of jump - jump through, which makes it challenging for our client group.

MS COSTOLLOE: Yes, particularly challenging when you're homeless.

MS YARED: Yes.

MS COSTOLLOE: Or transient, and you're struggling to meet daily requirements, let alone going through a formal process of assessment and, you know, making appointments to go through the application process and assessment process of the NDIS.

MS YARED: Yes. And then there's sort of a lack of assertiveness with certain NDIS supports. So for people who are particularly hard to reach, that might not be the most appropriate service, whereas community mental health sort of fared a bit better previously.

MS COSTOLLOE: I think, in regards to the NDIS, and supporting our client group to access the NDIS, what we've found is the best way forward in a lot of cases is to resource our staff group appropriately, with basic knowledge and understanding so that they can provide that assertive outreach support to bring people along for that journey of going through the assessment and application process, and touching into the clinical service system with the support of our teams, because that proves to be more effective for those people who are struggling to work through that complex system.

I think, other than that, we just wanted to, I guess, support the recommendations around the need for Housing First approach, and increased focus on Housing First and long-term housing options for people with chronic, persistent mental health issues, as well as the need to have a focus on sustaining tenancies as an early intervention approach in regards to mental health,

and ensuring that people don't go further down the track towards chronic mental illness, and just, I guess, the co-occurrence of mental health and homelessness being a strong focus in the draft report is very much welcomed by Launch Housing, in particular.

PROF KING: Well, you've said what you like our - okay, so I'm going to ask you the sort of, almost the obvious question, the important question, which is, you've said what you like about our recommendations; what recommendations, other than fixing the housing system, which we'd love to do, if there was - I was on another inquiry where we were trying to sort of do that, but that's another - that's a different story. What recommendations, what specific recommendations do you see that we haven't got that you think we need?

MS COSTOLLOE: That's an interesting question.

MS YARED: I think I probably talked about tweaking the recommendation 15.2, no exits into homelessness. You know, and I've already stated, it's very difficult to do that without the housing stock. There are some things that may ameliorate that a little bit, so I'd like the Productivity Commission to look at existing programs that are usually run in conjunction between housing services and inpatient unit that are working quite effectively. There are a lot of those across the country. We have one with the Alfred and one with St Vincent's called Housing Mental Health Pathways Program, HMHPP, and it provides that continuity support from the inpatient unit into the community.

It's usually short-term case management finding accommodation and stabilising that person in the community. So I think that perhaps looking at some of those programs that are effective would be a good way to sort of formalise that policy. I would worry about simply having a policy that says, you can't exit someone into homelessness without having that - that particular, very clear support of what that would look like.

PROF KING: The implementation.

MS YARED: Yes. Exactly.

MS COSTOLLOE: And the need for step down approach as well with that, where it's intensive, but also that it's something that can follow people through their recovery journey, and to make sure that that housing stability is something that is managed and maintained. I think there's a lot in the report around sustaining tenancies, and there is quite a number of great programs, including Tenancy Plus, Support for Families at Risk of Homelessness that Launch is involved in.

But there's a need to look at what's available as well for people outside of social housing. There is the Private Rental Access Program plus that is going to be rolled out shortly. It will be interesting to see how that can support a greater number of people around sustaining and not falling into homelessness, because as we know, that's a very traumatic experience for somebody, and particularly when you're already experiencing mental illness.

MS ABRAMSON: We're very interested in a number of the programs that you talked about, and I'm assuming you'll make another submission to the Inquiry. If you could include them, and thinking particularly, we know that one solution doesn't work for all, that there might be

a number of different solutions. So specifying for us which cohort of people you think that a particular program has been very successful with, that would be very helpful.

MS YARED: Certainly.

MS COSTOLLOE: Absolutely. Yes.

MS ABRAMSON: I wanted to ask a question. You said before about the transition, and people in the housing system actually falling between catchments, and we're particularly interested in this, because we've been thinking a lot, in another part of the report, how people access services, and we've been thinking about the current model of PHNs and LHNs. So really interested in exploring a little bit more what you've said about that transition issue.

MS YARED: Is there any specific - - -

MS ABRAMSON: In terms of your actual, practical experience. That somebody is in a particular service, they move to another state, or even across the road; so how prevalent is that?

MS YARED: Very common, even at something as small as 500 metres. It does depend on, I guess, the individual case manager and service in terms of how good that transition is. Sometimes there's room for advocacy. Other times, it's very much, no, sorry, they're not in our catchment anymore, if they're on. And, you know, I'm dealing with a case at the moment that's quite high-risk where it's been a very clear delineation of, they've moved out of our catchment, but the other service has not picked that person up.

So we've got a period of three or four weeks of very high-risk mental illness, and no support, and sort of other workers involved who are not mental health supports sort being the quasi mental health supports. So, long story short, it's very common, but it does depend on the individual case as to how far a service will go to making a good transition.

MS ABRAMSON: Because we've thought a lot about care coordinators. So we have thought a lot about the joining up of services. I mean, we've had a very narrow focus, because we've been thinking about people with mental ill-health, and of course, homelessness is a wide range of people. But any of your thoughts on how we can knit things together in a better way would be most welcome.

MS COSTOLLOE: We do have experience in regards to, I guess, Transition Support Program, previously PIR, where Launch Housing offered that sort of - that was involved in a consortium in the South Eastern Primary Health Network, where we working as - with a consortium where we were case coordinating people, and Launch specifically had a focus around people who were homeless who required that additional level of support, and it was very successful in supporting people to access the services that they really did need, and the care coordinator, Des, had a very good understanding of the language that was required to access that, as well as stepping people through quite closely, and working in a very good, collaborative, trauma informed focus. Yes.

MS ABRAMSON: Thank you.

PROF WHITEFORD: So, just one question. On the housing stock, some of the feedback we've heard is that clients with severe persistent mental illness who are accommodated, the challenge is the - I guess, supporting them in that environment, and the alleged impact on the housing stock itself.

MS YARED: Yes.

PROF WHITEFORD: Have you had that experience? And if so, is there a way to ameliorate that risk, if that's a real risk?

MS YARED: Are we just sort of talking about maybe antisocial behaviours, or damage to stock, and things like that, that would result in mental illness?

PROF WHITEFORD: Yes.

MS YARED: Yes. That's a daily reality of mine. I definitely think we need to look at the built environment for people with mental illness. I think something as simple as soundproofing certain stock. Yes, it is a tricky one, because we're always balancing the needs of the neighbours, who are often quite fearful, with the rights of somebody to remain housed and also receive the mental health support that they need. So it's a tricky question, but yes, it is a common issue and I do think we need to explore what sort of - what built environments are working for people with mental illness.

I think often high-density living is quite inappropriate for some people, so that, of course, has the added complication of increasing wait times if we are looking for medium-density. Yes.

MS COSTOLLOE: And I think Launch Housing is very keen for the Commission to consider permanent supportive housing options as recommendations in regards to longer-term housing options, because permanent supportive housing offers 24-hour supportive, you know, trauma informed care to people. It's secure, it's safe, it's affordable, and it can be done in scattered sites.

So you have a low-density option, it can, you know, it can also - but when you've got that 24-hour on site care, a lot of those risks can be reduced, when you're thinking about antisocial behaviour, damage, rent arrears, and those sorts of things, because you've got people there who are engaged with the residents on a daily basis, supporting them around their recovery goals, and offering - and there's, I guess, other support services linked closely to their housing, whether it's on site services or our Elizabeth Street Common Ground service has psychologists visit regularly, and we also have Alcohol and Other Drugs services who are on site, a nurse who is there most of the time to support people around all of those comorbidities that occur when you're homeless.

PROF WHITEFORD: If you were able to just, I guess, capture those learnings and experiences that you've had from running those services, and provide them to us, that would be gratefully received.

MS COSTOLLOE: Absolutely. That would be terrific. Thank you.

MS ABRAMSON: Did you have a - - -

PROF KING: No, please.

MS ABRAMSON: I have one final question, and it may not - I'm assuming that you have worked with people. Our recommendation about no discharge into homelessness also related to people released from correctional facilities, so interested in your observations, even if you want to take that on notice with the work that you're doing in that area.

MS COSTOLLOE: That would good. Yes, I think we do - yes, we would like to contribute something in our submission around that. I think that's very, yes, relevant.

MS ABRAMSON: Thank you.

MS COSTOLLOE: Thank you.

PROF KING: Thank you very much.

PROF WHITEFORD: Thank you very much.

MS ABRAMSON: Thank you.

PROF KING: And next we have Belinda Caldwell. The microphones are just for the transcript. If you could state your name and affiliation for the transcript, and then if you have any opening comments you'd like to make.

MS CALDWELL: Okay, thank you. So, my name is Belinda Caldwell, and I'm the CEO of Eating Disorders Victoria. So, I wrote some notes, if that was okay.

PROF KING: Yes, please. Please.

MS CALDWELL: So I'd like to talk to the draft Mental Health Report recommendations from an eating disorder's lens. At Eating Disorders Victoria, we represent the voices of those with an eating disorder and their families, as well as provide a range of support services. Our programs include peer mentoring, telehealth Nurse Navigation and care coordination support, support groups, and our hub service, which offers first line contact and support.

As many of you would know, eating disorders have one of the highest mortality rates of any psychiatric illness. Often emerging in adolescence or young adulthood, we know that prompt, comprehensive evidence-based intervention can change what can be a lifelong, chronic, debilitating illness into a one-off episode or episodic illness which can be managed. While the evidence about what works is still emerging, we know that a focus on early intervention, care coordination, evidence-based treatment, support carers, and appropriate responses from hospital are key.

Early intervention is key to detecting eating disorders early and onset, and acting aggressively to shorten illness duration and improve long-term outcomes. There are online assessment

tools, like Feed Your Instinct, for concerned families, and Reach Out And Recover, for those who are concerned about themselves. They should be part of any overall plan, so not just online treatment options, but online assessment options.

So online treatment option work extremely well with bulimia nervosa and binge eating disorder, and we strongly support any recommendations supporting developing these and making them affordable and accessible. Navigation of our eating disorders service system currently can present a nightmare, complicated often by the fact that someone who is unwell with an eating disorder experiences high level of treatment ambivalence due to anxiety. It often falls to the families and carers or others to find services, negotiate treatment access and support, or even allow the person into treatment.

Better service coordination and simpler care pathways would assist carers as well as clinicians. So we support the recommendation around the single care pathway, but just want to note that health pathways does not currently allow non-clinician access. So any solution would need to address this. Evidence-based treatment in young people predominantly relies on families and carers to do a form of hospital in the home, which requires around the clock care to refeed their young person and interrupt compensatory behaviours, until such time as they are able to eat and exercise appropriately.

There is emerging evidence that similar approaches in adult treatment may also improve recovery rates. However, the impact of this level of caring on families is significant, financially as well as emotionally. Research indicates that families of someone with an eating disorder have extremely high levels of carer distress, often associated with anxiety and depression themselves. To reduce carer burden, we'd recommend much higher levels of support for families.

In terms of building skills and knowledge on how to care, much stronger integration of carers into assessment treatment planning and discharge processes. Recovery for someone with an eating disorder is much more likely if they are robustly supported in the home environment for a significant amount of time, and carers require educating in areas such as meal support, distress tolerance, to increase self-efficacy in reduce burnout.

We support the recommended changes to the carer payment access, as many of our community have found this difficult. It should be noted that generally the carer payment support is poor recompense for lost income and the costs of the illness. Effective respite options, skilling of schools to do meal support, awareness of workplaces of the practical requirements of refeeding a loved one are also some of the supports that are needed.

Hospital in the home options are only briefly mentioned in the report, but would be an effective treatment option for those with an eating disorder on discharge from hospital, to reduce the all too frequent relapses. One of our concerns are where there is any separation of mental health out from physical health. People with eating disorders often require both medical and psychiatric care, and the universal experience is that the different systems can do their part well most of the time, but not the other.

In the outpatient setting, the person will need medical monitoring and dietetic support, alongside the psychological therapies. Currently, in the hospital setting, if someone is in a

medical ward for medical stabilisation, clinicians can be unskilled at meeting the mental health needs of that person, and when in a psychiatric facility, the person's nutritional refeeding requirements are often not met. When people are significantly malnourished, they can experience higher levels of suicidality and anxiety, and nutritional rehabilitation is key to their mental health as well as physical.

Finally, specifically from an EDV perspective, we are concerned that the role of NGOs in mental health is not delineated strongly enough in the report, and are unsure where they fit in the rebuild model. We provide key services for people with mental illness, especially in the peer mutual self-help space for both those with an illness, and their families and carers. Our funding is majorly provided by the Victorian state government as a single funder, and we would ask that any final report recommend reliable, sufficient, and simple funding streams for this vital part of the mental health system, and avoid any unintended consequences in any recommendations.

PROF KING: Just a very, well hopefully, a very simple one, and then I'll pass on to my colleagues.

MS CALDWELL: Yes.

PROF KING: And this may again be something that the team knows, but not something that I've realised. You mentioned online assessment and treatment for eating disorders.

MS CALDWELL: Yes.

PROF KING: And I guess, behind it - I understand completely the sort of triaging part that needs to be involved in any online service, but you said the online treatment works well, which did surprise me for eating disorders, having talked with, I suppose, some of the (indistinct) and carers, or people with lived experience, I guess, like (indistinct) and carers, about the issues of recognition by the person of their disorder. So I was quite surprised when you said those online - that online treatment works well, so do you mind expanding on that?

MS CALDWELL: Sure. I think probably what happens is that a lot of the voices that people hear from, and we're as guilty of this, is really referring to anorexia nervosa, which is actually the rarest of the eating disorders. So for bulimia and binge eating disorder, there is a lot more motivation from the person to get better from those illnesses.

PROF KING: Okay.

MS CALDWELL: And we do have really quite strong evidence, both in face-to-face and online, that aversion of cognitive behavioural therapy for those two conditions are very effective. And in some ways, the online option is less shaming for them than actually, you know, going to see a psychologist about it. So I am referring - I'm not referring to it in terms of anorexia.

PROF KING: Yes. Okay.

MS CALDWELL: That's all right.

PROF KING: So it was my misunderstanding. So please, Harvey, would you like to?

PROF WHITEFORD: So with the MBS side changing, what's the reception from the sector with respect to their value and the - what you can cover through that sort of treatment versus broader needs that the client group are going to need?

MS CALDWELL: I mean, I think they're already making a significant difference to access to psychology and dietetics. We're obviously in very early days to see how it all plays out, but I think, you know, there's been - long been a need that if someone is going to have therapy, evidence-based treatment for eating disorders, that they need more than the 10 visits under the old scheme.

I think what is yet - still need to be sort of worked out, I guess, is when someone really needs that even more specialist, intensive part of treatment, and what we don't want to see over time is public sector programs going, okay, well these guys have now got an MBS item number, that can happen out there. Because it still is pretty tricky for an - a fully outpatient team. If someone's really unwell and may need hospitalisation, or really intensive supports for their families and carers and, you know, and it's a really, really, serious mental illness, that generally is better provided in our public system.

PROF WHITEFORD: And I guess the support for the family component, because they're often a younger adolescent, for example, are there services available for the families?

MS CALDWELL: There's not a lot. So, what we've seen, particularly in the adolescent thing is a real shift to family-based treatment, which it has been most evidence-based at the moment for effective treatment, which relies fully on the family being at home, doing all six meals, 24/7 care for extended periods of time. Which has been great, compared to parents previously being kept out of the treatment, but it - there's not a lot of support. Some public services are looking at additional cycle education for families, support groups. There's not a lot outside of that. And particularly in terms of respite or anything like that, there's really none.

PROF WHITEFORD: Okay. Thanks, Stephen.

MS ABRAMSON: Could I ask a question about the peer mentoring program? We're very interested - - -

MS CALDWELL: The what, sorry?

MS ABRAMSON: The peer mentoring program.

MS CALDWELL: Yes.

MS ABRAMSON: We're very interested in the role of peer workers and what more we can to do to support that. So very interested.

MS CALDWELL: We've had a peer mentoring program for, I think it's three years now. Essentially, it started off as a philanthropic funded program, and has morphed across to being a DHHS funded program, because it's been very effective. Essentially, it's for people coming out of hospital or a day program, and it provides them with three hours a fortnight with someone who has fully recovered from an eating disorder. And they do a whole range of things. They can go out and, you know, have lunches or they can, you know, just hang around and chat or they can go for a gentle walk somewhere, or something.

But the idea is that that person provides mentoring for that - and what we've found with that is there's a whole lot of stuff that has to sit behind that, but what we have found that is we've really significantly reduced hospital readmissions, and that's hence why the state government ended up taking over the funding of it. Does that answer the question?

MS ABRAMSON: Yes, yes. Well, one additional issue. I was just interested in the words you said about someone who's fully recovered. One of the issues we've been looking at with the peer workforce is the type of capabilities and skills that a peer worker needs to actually have. So I'm assuming you've got quite a screening program and a - - -

MS CALDWELL: I mean, it's a little bit arbitrary in some ways. We require people to have not engaged in any eating disorder behaviours for at least two years. On top of that, you know, it sounds - I don't know, it sounds overly bureaucratic possibly, but we screen both the participants and the mentors with something called the EDE-Q, which is our eating disorder assessment tool, and then we provide quite robust support for both the participants and the mentors behind the scenes, with our own staff.

So if the mentors are ever triggered or concerned, they've got an open line to the - and we're actually proactively going into look for that and support that. I think it's an interesting scenario, where we - yes, to how - my view is we're better off managing that risk than avoiding doing the peer mentoring.

MS ABRAMSON: If you were intending to put in another submission, and I hope you are, we'd be quite interested in having some more details about that program.

MS CALDWELL: Definitely. Will do.

PROF KING: No.

MS CALDWELL: Thank you very much.

MS ABRAMSON: Thank you very much.

PROF WHITEFORD: Thank you.

PROF KING: Next, I'd like to call up Dr Ann Moir-Bussy. Good afternoon, Dr Moir-Bussy. If you could state your name and any affiliations for the transcript, and any opening comments you'd like to make.

DR MOIR-BUSSY: Thank you. I'm Ann Moir-Bussy. I'm the Vice President of the Australian Counselling Association, but I'm here today speaking as a private practitioner, as a counsellor. Thank you. I've been a counsellor since 1992, and working in private practice. I've also worked with the Social and Emotional Wellbeing centres in the Northern Territory for a number of years, at Darwin, Katherine, and Alice Springs, and helping the Aboriginal counsellors to develop - and I also developed a diploma in Aboriginal Family and Community Counselling at the University of New England, and for five years, helped them to work.

Over the years, many mental health problems that have been quite frightening in those areas, quite sad, where people cannot access the help that they need. Your report, I think, is really great. I was at MBS meetings in the last 12 months in Canberra, and where there was a lot of discussion around the provision of mental health services for people who most need it. One of the things you talk about is there's not enough early intervention, that's preventing people - that's helping people from developing long-term mental health problems.

And I think part of the difficulty is that we as counsellors are left out. We're not recognised for our qualifications, for our training, and for what we can provide for those people. And as a private practitioner, this is really one of the hard things for us, particularly for me when I have to turn people away. People who come to me with depression because of divorce, relationship problems, suicide, looking after Alzheimer's in their family. People who are really suffering, and I can see them for nothing, but we don't get support and they don't come because they can't afford to come.

And I think this is one of the things missing in the report, where allied health professionals are listed rather generally, but counsellors are not included in that, and I'm talking about registered, qualified counsellors. I'm not talking about just anyone who hangs up a shingle after a weekend of training. I'm talking about people who have that long service and long commitment to people. Over the years, I've dealt with a lot sexual abuse. I live in Ballarat at the moment, where I've set up a private practice. I've retired from teaching at universities, and live in Ballarat. There's a huge area of sexual abuse that needs to be addressed there.

A lot of people suffering from that, and I've run lots of sexual abuse programs that help people heal from that. We are unable to provide those - we can provide them, but they can't afford to come, and this is the sort of thing, I think, that the Commission really needs to look at, to give this opportunity that people can have that choice of going to the person that they want to go to, or getting the help that they want to get without having to go through a long waiting process, or being told they have to see a qualified psychologist or a psychiatrist. That's certainly needed for people who are really, really sick. But a lot of people in the early years don't need that. Any questions?

PROF KING: I'll open it up to my colleagues first.

PROF WHITEFORD: So, I guess the scope of practice for the counsellors, how would you see that fitting into that? You've probably seen in our report, we refer to the Stepped Care Model of service provision. Have you had some thoughts about where counselling and (indistinct) fits into that sort of a - - -

DR MOIR-BUSSY: We certainly feel that we do fit into that model, not just in the very early intervention, but also the moderate, and being part of a disciplinary team in the complex care provision too. I was in Argentina a few years back where there was a good example of that psychiatrist, psychologist, counsellors, massage therapists, all working together in one system. And that kind of support that was needed was really valuable to see.

PROF KING: You mentioned MBS, and I mean, which is sort of the elephant in the room, if I can put it that way.

DR MOIR-BUSSY: Yes.

PROF KING: In some ways, our recommendations though, we've not looked at expanding MBS services. If anything, we've made recommendations over time that, for example, down that moderate acute end that it could (indistinct). It depends on the evidence, but it could potentially move to more commissioned services, while at the mild end, we're looking for moderated online type of services.

So, I guess my question is, in a system where we're moving online - moderated, online at the low intensity, more commissioning of services up at the upper end, where do counsellors fit in, and if - is it really necessary for the counselling workforce to be part of that MBS, which does open up a - I understand it opens up a bucket of funding, but it also opens up a bucket of expense from the taxpayer's perspective.

DR MOIR-BUSSY: We're mental health practitioners, in that sense. We've studied mental health. We're trained in mental health, in psychology. I do a lot of focus on positive psychology, which helps people to move forward in a much more positive way and get to where they want to be. Online programs, we're very familiar with online programs. I do a lot of counselling online, by Zoom, by Skype, helping people that way. And there's a place for counsellors who are trained in all the - we're trained in CBT, we're trained in all the things that psychologists offer at that level.

There's a space for us to be able to provide, particularly in regional and remote areas. Areas where there's not access to psychologists or to counsellors, and I'll give you an example. I had phone call just the other day from a couple who are older who wanted to access counselling services. Their marriage is a little bit shaky because they're getting older and they can't handle it. They wanted help, but I didn't have MBS, so they can't come. They said they have to wait a long time to see a psychologist. And they looked up our qualifications, what we do. I get this quite often. So there is a place.

PROF KING: Do you see counsellors as being, in that online space, which would be - I'm not sure if you're familiar with PORTS over in Western Australia, but that a broad online program which would involve both assessment and the delivery of - assisted delivery of online counselling services, CBT.

DR MOIR-BUSSY: Yes, very possible.

PROF KING: Yes.

DR MOIR-BUSSY: Some of this do this already.

PROF KING: So do counsellors have a role in there?

DR MOIR-BUSSY: Some of do this already, but without any support.

PROF KING: You mentioned as part of teams. I mean, again, that's - I guess our recommendation is to look at that through commissioning. Is that an approach that you think is appropriate, or?

DR MOIR-BUSSY: It is appropriate, in a team. But I think the other thing I'm saying is, as private practitioners too, while we can work in part of a team, there's - we have over 5,000 members. That's a huge workforce that's being ignored when people are in need, and I'm thinking of the consumer more than just what we want. There's so many people just longing for help and not able to get it.

PROF KING: Other comments?

MS ABRAMSON: I just want to ask, and you might want to take this on notice; you mentioned before that you had worked with Aboriginal communities, and we have a number of recommendations in terms of support services for Aboriginal Australians, so I'm just interested in your experience, particularly in that counselling, mental health space, and training up an Aboriginal and Torres Strait Islander workforce.

DR MOIR-BUSSY: Yes. When I was training them, we would have had about 20 in four cohorts over the time I was there. 20 in each cohort, and a lot of them have kept in touch since then. They need to be trained from that cultural perspective so that they - they're able to use their own ways of working and then able to use their own traditions of working with people within their own communities, and they found that really, really important. I still get requests from them when I come sometimes and work with them in that area, and I'm not able to do so now because of where I am.

But I think that's a very important area, where more training is provided for them and more support is given to them so that they can actually work better. That training program has gone now from the university, and only last year, I had requests from some of the original trainees. Their communities still need it, and would we develop something else for them, which I'm not in a position to do now, but that sort of need is still there for those Indigenous people.

MS ABRAMSON: Do you know why the program was discontinued? Was it a funding issue, or - you don't have to say, if you'd prefer not to.

DR MOIR-BUSSY: I moved to Hong Kong to teach for five years, and then I think the person who took it over didn't want to keep it going. It's one of those things that happened within, you know - programs come - and I was training people in Hong Kong at that stage, so it was a bit different.

MS ABRAMSON: No, look thank you very much.

DR MOIR-BUSSY: Thank you.

PROF KING: Okay. Thank you.

DR MOIR-BUSSY: Thank you.

PROF KING: So the next person we have is Michael Blair. Michael, if you are able to state your name, affiliation, and - for the transcript, and any opening remarks.

MR BLAIR: My name is Michael Blair. I'm a retired specialist mental health nurse. I have 45 years working in Victoria, Queensland, NSW, ACT. Mainly down the east coast, and I've worked in management planning across ministry in NSW, and also in trade union movement. So I have a broad scope, if you like. Now retired, but passionate about mental health, and specifically specialist mental health nursing and its future.

And my soapbox, I guess, is that the recommendations made in s.11.4 in relation to workforce I fully recommend and commend the Commission for its insight into what are some of the solutions for the future workforce, and specifically in relation to specialist mental health nursing. I see, throughout my career, mental health nursing as being devalued and its expertise is being ignored, and I think the only way that we can avert that is to return to and revisit specialist mental health nurse registration in this country.

It was something that we valued and we lost with the national register and APRA, and because mental health nursing is a small minority in the scheme of things, in the overall nursing workforce, we are a mouse that roars and we are roaring at the moment because we see that our skills are at threat, and have been for some time. A number of facilities are now employing nurses without skill to fill the spaces that they are unable to fill with nurses with quality and qualifications and expertise in mental health, and that is leading to some of the safety issues that we see and some of the quality issues that we see that are disappearing from our mental health sector.

Another soapbox that I have is the national - the Mental Health Act, and I've had experience as a mental health tribunal coordinator in one position that I held for some time, and I have been a party to a number of reviews of Mental Health Acts in different states, both Queensland, ACT, NSW, and Victoria over the period of my career. And having worked in the ministry, I've also seen the number of bureaucrats that are employed to oversight memorandum of understanding to ensure that the gaps in service, as people transition from one state or jurisdiction to another, are required to ensure that their treatment is continued.

And the amount of money that goes into ensuring that that takes place led me to think that wouldn't be nice if we had a national Mental Health Act. Now, I understand that from a constitutional perspective, this is a big ask, but we have been able to see overarching acts of parliament and state jurisdictions and territories still maintain the quality in the service provision and overall management of the tribunal and the act within their - each state.

But it then provides us with this overarching ability to reduce the number of reviews. Every time we have a need for a review of mental health legislation, we go through a whole process,

there's an enormous amount of funding that's allocated to oversight that review and the formation of the new legislation for each state or territory. And those reviews are necessary, but wouldn't it be nice if we had one review that would be overarching, and if we're looking at ways in which we can be more productive, then this is an opportunity, and when we can say, look, wouldn't it be great to have a national Mental Health Act, it's a soapbox that I often stand on, but it is something that would be ideal.

There's a couple of other points that have been raised that I'd like to address while I'm here, and I have made some notes. One of the issues that I raised at the Victorian Royal Commission into Mental Health when they asked, what is it that you think works well, one of the positions I held was coordinator for the Second Psychiatric Opinion Service. It is an independent psychiatric evaluation of those that are held compulsorily under the Mental Health Act in Victoria. It's a requirement under the Victorian Mental Health Act.

It is not a requirement in other jurisdictions, as I understand, having worked in Queensland, NSW, and ACT. But it is a service that is provided here in Victoria, and it provides the individual with a plain language explanation and recovery plan in a written language that they can understand and that they can share with their relatives about why it is that they're being held under the Mental Health Act. Often, people that are held under the Mental Health Act against their will feel as if they've reached a dead end.

They've got no way of getting a second opinion, other than from internally within the service, and often an independent psychiatrist that is available and has the specific purpose of giving them a plain language explanation as to why they are under the Mental Health Act, gives them hope. And it is one service that I think is - it's not spoken of enough. It does work well, and it needs to be commended, and if it could be rolled out across the nation as a service for consumers, I think it would be of value. So I give that a plug.

I think, just reflecting on previous contribution to the Commission, Indigenous mental health is an area that I also have some understanding of. I'm pleased to see that Frank Quinlan has now been allocated the position of CEO of the Royal Flying Doctor Service, and I think that the positions of mental health nurses working in that service is something that we also need to promote. They provide consumers that are in remote communities with a service that is another gap in services that we understand is there. But the other valuable resource is trained Indigenous mental health workers that understand culture and understand the needs of our Indigenous and Torres Strait Islander communities. And I think that they've been undervalued.

Undergraduate direct entry; another issue that was highlighted in, I think, your recommendation 11.4. I have recently, at the Australian College of Mental Health Nurses Conference in Sydney, put a motion to the floor that we should return to undergraduate direct entry. I know this is - my colleagues from the ANMF don't see that this is of benefit, but I see it as being one of the ways in which we can ensure a future workforce, and I know that Professor Brenda Happell has a curricula that is already written and available for any universities that want to take that up.

Issue of mental health being provided to persons who are under remand in correctional services. Having worked with homelessness and in the area of corrections and forensic

mental health, my concerns are that persons that are held in remand have the ability to refuse mental health treatment and are not placed under the Act until they're released off remand. Often they are released into public mental health services, and are released when extremely unwell because they have not received treatment whilst in remand.

I understand that there are legal issues involved, but that it is of deep concern that if someone is of - in need of treatment and in remand, and can be in remand for a long period, that those people deserve treatment, and deserve treatment as should any other member of the public. And it places those persons that are members of the public in public facilities under serious threat, because they enter those facilities severely disturbed.

So I leave that with you as a comment, and I don't see a resolution. I don't know what the solution to that one is, because of the legal issues involved, but it is of concern to both those people that work in remand in the correction services, and also those people who receive those clients into the public facilities.

NDIS. Having worked with homelessness and trying to have people assessed for NDIS assessment, it is very difficult for anyone who is homeless, without ID, without an email, without an address, to attain an NDIS assessment. This needs to be addressed. There need to be specific people working in the NDIS sphere that have their role specifically to address those people who are in homelessness.

And on another note, in relation to housing and homelessness, I believe that there should be no discharge from facilities into homelessness. It is something that has occurred time and time again. It is something that has been somehow subtly accepted by the demand for, and pressure for beds, but that is not acceptable, and was never acceptable in my day, but it is becoming more and more obvious as we see more and more pressure for beds.

PROF KING: Just before I pass over to my colleagues, I just wanted to clarify something you said. You referred to people in remand getting treatment. You said people in remand can refuse treatment, mental health treatment, but then you said later on people on remand deserve mental health treatment. So is the issue that then - that people on remand are not eligible for the treatment, that they would receive treatment (indistinct).

MR BLAIR: Yes. There are people - - -

PROF KING: If you could just clarify.

MR BLAIR: Yes. There are people in remand that accept mental health treatment, and understand that they need mental health treatment. They have the insight to believe that they require a continuation of their treatment. But there are people in remand that are so unwell - and we do see severe mental issues presenting in remand - but their insight is extremely limited, and they can refuse treatment and become even more unwell and end up in isolation. And again, that's not a healthy situation either, whilst in remand.

PROF WHITEFORD: Sorry. So to clarify, the issue is the inability to involuntarily treat people - - -

MR BLAIR: Correct.

PROF WHITEFORD: - - - who are in remand, because they're held under - - -

MR BLAIR: Exactly.

PROF WHITEFORD: - - - a section of the criminal code, or whatever that state or territory has.

MS ABRAMSON: Yes. Yes, there's a legal issue. Whereas if they were subject to a community corrections order, or some other form, the court can actually impose conditions on that.

MR BLAIR: Yes.

MS ABRAMSON: But being in remand, they haven't - they have not been found - - -

MR BLAIR: That's right.

MS ABRAMSON: - - - guilty of the offence.

MR BLAIR: So the legal issues that compound their treatment, you know, that's the obstacle, and there is this position where, how do you resolve that, both from a legal perspective and from a medical perspective?

PROF WHITEFORD: Sorry, they're denied treatment that would, had they not been in remand, would have been provided with?

MR BLAIR: They would have been provided treatment.

MS ABRAMSON: Mr Blair, look that's been incredibly helpful. I was wondering if you might take something on notice, bearing in mind the time constraints.

MR BLAIR: Yes.

MS ABRAMSON: That Second Psychiatric Opinion. It doesn't have to be an extensive submission to us, but I'd be really interested in knowing a bit more about your work in that area.

MR BLAIR: Certainly.

MS ABRAMSON: Even a short submission. It just sounded - - -

MR BLAIR: The program is run between Monash Area Mental Health Service and NorthWestern. They have a partnership, so the service is provided statewide, and I can get you more detail on that service.

MS ABRAMSON: Yes, that would be good.

MR BLAIR: And it is supported by IMHA and the legal, and the beauty of that is that they can actually take a submission to a tribunal hearing and use that as evidence to the tribunal.

MS ABRAMSON: No, I'm really interested, because some of our recommendations actually go to the provision of legal or advocacy support for people before tribunals. So very interested in having a look at that model. Just mindful of the time.

MR BLAIR: Fine, thank you.

PROF KING: I was expecting you move onto the Mental Health Act.

MS ABRAMSON: No, I'm mindful of the time.

PROF KING: All right. Thank you very much.

MR BLAIR: Thank you for your indulgence.

MS ABRAMSON: Thank you.

MR BLAIR: And allowing me the opportunity to speak.

MS ABRAMSON: Thank you.

PROF KING: Thank you.

PROF WHITEFORD: Thank you.

PROF KING: Right. Now if we can break for lunch and perhaps reconvene at 1.30, I think would probably be the best time. So, thank you, and see you in 55 minutes.

LUNCHEON ADJOURNMENT

RESUMED

PROF KING: Let's reconvene the hearing, and the first person after lunch, Marie Piu.

MS PIU: Thank you.

PROF KING: And if you could state your name and affiliation for the transcript, and if you have any opening comments.

MS PIU: Thank you. My name is Marie Piu. I'm the Chief Executive Officer of Tandem, the peak body for mental health carers, or a trusted voice of family of friends in mental health, as we like to call ourselves in Victoria. We're also the Victorian member of Mental

Health Carers Australia. I believe you've already received testimony from Mental Health Carers Australia.

The focus of my presentation today is really a synopsis of what we've lodged in terms of a submission, and also some of the considerations we have as a result of reading your report. So there are number of things in the report that we commend, and there are some things that we note in the report that are, we believe, missing. And one of the major things that's missing in the report thus far is an understanding of relational recovery. We note that you refer to relational recovery, but there seems to be a disconnect between the words and the meaning behind relational recovery.

So when we talk about relational recovery, we're really talking about recovery that isn't based on the individual. The report very much talks about the consumer, the consumer, and the consumer, and I understand that. However, the reality is that people don't live as independent beings without any connections to others, and that doesn't come through in the report. So even though you've got quite a significant chapter on families and carers, it doesn't come through, and the understanding that interdependence is really the optimum that we're looking for, rather than independence, doesn't come through.

One of the things that that - why that's particularly important is that in Australia, and it's particularly in Victoria, about 25 per cent of the population have a parent born somewhere other than an English speaking country, and yet, it's not reflected in this document at all. I didn't get a sense that there was an understanding that recovery doesn't happen in isolation, and that unless the whole network around the person that has either the diagnosis of the mental health and wellbeing issue is supported, that that recovery is going to be sustainable.

The reality at the moment that we have, and particularly in Victoria, is that with the decimation of the community mental health system, we have a largely acute system that operates in crisis. It's not able to deal with the demands. GPs very much open - work from an individual model. They deal with the person in front of them, not necessarily communicating with family. There is an argument that perhaps when there are young children or teenagers involved, that's different. That's not generally the experience that we hear at Tandem.

So at Tandem, we are largely funded by the state government. Well, we're almost completely funded by the Victorian state government. We run something called the Carer Support Fund, which is a \$1.5m fund that provides financial assistance to families where someone is associated with an area mental health service, and that's capped at a maximum of \$1,000 a year. The reality is that it's so overspent, or so much in demand, that some services are putting in caps of two and \$300 because they're unable to meet the demand.

So that's a discussion we're having in Victoria, but there isn't something similar that occurs in any other state, and also there's no opportunity, for instance, for families who are perhaps seeking help through primary health network programs, or through other means, to actually access any financial support.

So that's one thing. The other is that we've recently been funded for individual advocacy. We have something we call a carer support and referral service. In the report, we note that

you particularly talk about advocacy from the consumer perspective, and you talk about the likes of IMHA, where someone is a compulsory patient. The issue that we've found is that families are desperately in need of some support and advocacy, and we've been providing that both in the NDIS context through the transition support program at Tandem, and also generally.

And the calls that we're getting are around families being desperate, not knowing what door they can knock on to actually get support for their family member, usually - probably, in the main, they would be parents of teenagers who are suicidal, and who are basically being knocked back from all sorts of services, whether it be a Headspace, whether it be from clinical mental health services because they're not ill enough, Headspace because they're not - they're not sort of moderate enough, shall we say, or because they've got wait lists that are several months.

The community mental health services, of course, have lost their funding in light of the NDIS transition. So they're often not able to help, and a lot of the carers that are calling us are being told by the community mental health services they previously had support from, they can't be supported because there's no funding. So we're in that sort of no man's land in between. So the calls that we're fielding are very much around people feeling lost and feeling the despair that they're alone, and nobody seems to recognise that if it wasn't for family and friends supporting people with mental health issues, those people would not be able to maintain wellbeing when they gain it, if they gain it.

And so, we've got a situation, very much in the Victorian context, and around the country with (indistinct) counterparts that families are de factor case managers. They're often trying to sort out housing issues. Now, one of the things in the submission and your recommendations is that we very much welcome the changes to the carer support funding. That's very welcomed, but it's probably the only thing amongst your recommendations that actually stands out as something that's really positive from the family perspective, because you talk about things, you talk about family, but it's fairly empty for us.

So we're really needing to see more oomph. Now I know that individually you understand the role of families; it doesn't come through in the report. So we're wondering what we can do to assist in that process. You also talk about lived experience workforce. In Victoria, we're fortunate that we've got quite a well-developed lived experience workforce. We have carer lived experience workers. We're quite advanced, and we also have a framework, and I've brought a copy that I'm able to leave with you, which is a strategy for the carer mental health workforce in Victoria. It's a very, very good strategy.

You talk about piloting a system nationally, but we already have that system, so it would seem a shame to pilot something when we're actually running something in Victoria that has the makings of a good system. And the other thing that I would also observe is that the bias in the document is that it's very heavily biomedical, and whilst medicine plays a very important role, as a mother of a - as a daughter of a mother with serious mental health issues for most of my life, she's dependent on psychiatry to keep her relatively well, even though a lot of the side-effects she now lives with in her aged years are as a result of a lot of those medications. So I can resonate with what I've heard from previous speakers.

The reality is that we need to be thinking in a more contemporary way, and there are models in place, like Open Dialogue, and other systems in Victoria, and I'm sure around the country, that we could be investing in. But the document seems quite narrow in its focus. Is it that enough for now?

PROF KING: Yes. That's fine. Thank you. So I'll ask you the same question as we've asked some others in this situation. What would you want us then to recommend to the government to do? So not a statement about, well - along the lines, you know - because we all recognise families, friends, carers, are all critical for what we see as the consumer-centred approach to mental health care. We certainly don't see, and I presume you're not suggesting, there's a conflict there. There's just understanding. You have the consumer at the centre, and then you have the support network around the centre, and you have the other psychosocial supports as well as the clinical supports. But if we've got things wrong, or we haven't gone far enough, exactly what would you like us to recommend the government to do?

MS PIU: First of all, understanding what relational recovery means. That it's time to move from the individualistic model of recovery to one that's relational. So it talks about interdependence. I think that, particularly in a diverse society as we live in, we need to think about that in that way. If you're working with Aboriginal communities or multicultural communities, in which I've worked a lot, you can't work from that frame. The frame makes no sense. People are connected to either other.

And so, in order to support families, you need to provide them with support in their own right so they understand the experience. At the moment, as you would have seen in a lot of submissions, families are saying that they're excluded from information, they're not provided with support, all sorts of things. Even things like respite. There's a sense that respite is generic, but mental health families would tell you that respite needs to be provided in a mental health context. There needs to be understanding, and the staff that provide it need to understand mental health.

It's not enough for someone to just sit in a room with someone and - while you go out, because the family's not going to feel confident that that person is going to understand the context. So we have been involved in a lot of those conversations, so I think that thinking beyond the biomedical, and understanding its place, but understanding that we need to move more contemporary in our approach to mental health and wellbeing. That it's about all of the things that, I guess, contribute to a meaningful life, and that means that people are able to access all sorts of modalities.

And I heard what Ken said earlier about the farm. Fine. It sounds like a great idea. There are a whole lot of contemporary models. I saw some in Yale recently when I was there. A model called Access where you have, for instance, paediatricians who are able to ring in and speak to a psychiatrist, a social worker, and a family peer worker, who can actually talk about the issues that are going on for the family, and then they follow up and make sure the person's been linked into services.

I know that the American model is different, because it's a fee-for-service model, but models like that are actually really good. We don't have anything like that at the moment. PHNs have potential to fund those programs. So PHNs, in their commissioning, it would be great to

have recommendations that when programs are being commissioned, that they understand it from a family point of view. At the moment, it's still very individual. Very individual.

PROF KING: I'm still having trouble understanding what you mean by individual versus family. I mean, my understanding of individual, that it's focused on the consumer. It's focused on the individual from the perspective of their mental health. But I don't see that in any way as being inconsistent with saying that individual is supported through their families, their friends, their network. That's a critical part of their recovery. But you seem to be putting those as alternatives. That if we say it's focused on the individual, or consumer-centred, then somehow we're downplaying them. I see that as a false dichotomy, quite frankly, so I don't understand what you're saying.

MS PIU: Okay. I think that perhaps I'm not being clear enough. What I mean is that obviously the person that is living with the mental health issue is at the centre of the conversation. But they don't live in a vacuum, and they have a huge impact on the people around them, and the people around them want to be helpful in the situation. But the supports are not provided for those people to be helpful, and often it actually causes destruction.

A lot of us have experienced families that have broken up and been destroyed by a situation that hasn't been - - -

PROF KING: (Indistinct).

MS PIU: - - - you know, that it hasn't been managed or supported. So that's what I'm saying. So it's just that often what happens is that it's about the individual, and the therapeutic approach is not to say, who are the supports around this person? How do we provide support to the team?

PROF KING: The supporters.

MS PIU: Yes.

PROF KING: Yes.

MS PIU: We just think about the individual, and that doesn't work, and the staffing services are really critically important. But they're not able to do their jobs either, because they're usually dealing in crisis. And they speak to us and they say, they have no time to spend with people in distress. They've got to get on and do their paperwork, and they've got to get on with things that they actually didn't sign up for when they did their training. Yes.

MS ABRAMSON: Can I pick you up on that?

MS PIU: Sure.

MS ABRAMSON: Like Stephen - and thank you for appearing today - like Stephen, I'm - it was never the Commission's intention that we had a view that there's the consumer, and it's all about the consumer, and we did take quite a lot of care with those carer chapters, to think

about what that looks like. But we're really interested in what are the concrete things that we can recommend? I take your point about advocacy support for families, and we have been narrowly focused. I mean, we've been thinking about in the mental health tribunal.

So, like Stephen, I'm trying to be quite clear about what are the things, apart from our recommendations on income support and carer support and payments, that practically you would ask of us?

MS PIU: I think that providing supports to families in their own right so that they can maintain the relational - the relationship they have with the person is really important. So I saw a model, for instance, in Israel called Nilarm, which is network of family services throughout Israel, and it's bipartisan, and it's funded and families can drop in there and they can be supported in whatever way they need to be able to continue in their caring roles with their family members.

I think it's about the mental health focus. So it's not a one size fits all approach to support for families, and I think that there's a real tension there for us that we hear from family members, because they feel that a lot of services are moving to a homogenous model. And the other one is online models. So another thing that I saw in the United States is there's a push back against online models, and the reason for that is that people want human contact. They want to be able to sit with someone when they're distressed and actually talk through and work through what the issues are.

So if we could have those sorts of programs funded, that would be very beneficial. I think the Housing First model that you propose is also very good. A lot of families talk to us about the fact that their family members are being discharged to homelessness. The reality at the moment is that unless people have families in their lives, that they're a much greater chance is they're going to end up homeless, in jail, or dead. And I hate to put it that way, but the reality is, that's what we're experiencing.

And so, if we don't support those family and friends to be able to actually provide the support they want to, and not become collateral damage, because I think the other side of it is that there's this taking for granted that people are just able to continue on with the sorts of distress that they're experiencing, and their family member experiences, and feel powerless to change anything, and that's going to be okay and they're not going to develop their own mental health issues.

So I think that's all very important. The other thing is that I think the proposal of GPs being able to see family for four sessions is a good one, and I see that you're looking at expanding - some of the recommendations are around also providing other supports under the MBS. I think that's very important. And also, the carer peer workforce. I think the expansion of the carer lived experience workforce, and again there's - we have a lived experience engagement framework in Victoria that talks very clearly around codesign and coproduction. I think all of these things need to be done in that context and so I can provide that to you so you that again. That's been developed, it's a very strong document, it's got buy-in from consumers, carers and services and again we don't need to be reinventing the wheel, these things are here and it's about designing responses that are actually going to meet the needs of the people who are critically at the centre of it which are consumers and their families.

MS ABRAMSON: Can I ask about CALD communities?

MS PIU: Sure.

MS ABRAMSON: We certainly, as part of our consultative process, met with a number of communities but what we'd really like to know is what type of recommendations, given the vast multicultural nature of Australia, what could we practically recommend for different (indistinct) communities and I'll give you a point in time: we've noted some commentary around organisations that provide phone support, that they're not as agile in terms of providing support for different communities so we are open to ideas in this space?

MS PIU: Obviously phone support will never replace face to face support. I did 11 years in transcultural psychiatry so it's my great passion. I also come from a multicultural family and I can honestly say that we tend to blame stigma for people not coming forward to use services but I think that's a cop-out frankly. I think it's because we don't provide services that are culturally appropriate or sensitive.

MS ABRAMSON: Yes.

MS PIU: I think if we provided - someone said at a recent conference we ran, 'If we get it right for multicultural refugee and Aboriginal communities we'll get it right for everyone'. We've really got to think the most marginalised communities in our midst are the ones that need to feel safe and comfortable that those services are actually providing services that are appropriate. I think minimum interpreter services, obviously, having been used as an interpreter as a child I don't recommend that, and I would hope it doesn't happen but I know it does so interpreter services are in minimum but language is more than words.

Language is about many explanatory models of illness, and I know Harvey understands this very well, but the whole idea of working with explanatory of models of illness and actually start understanding that is really important but I do think it comes down to the culture of the system. We don't have a compassionate system. People talk to us about the lack of compassion and kindness in the system; that's not because we don't have good staff. That's because the system is at breaking point and I think that unless we can actually change the culture in which we're operating as a society and as a - not just mental health, health system, because mental and physical health are closely interrelated, nothing's going to change. So with (indistinct) communities, a term that I don't particularly like, but with, you know, - - -

MS ABRAMSON: I'm just using that as a - - -

MS PIU: No, no, I understand. But with multicultural communities I do believe that it isn't a matter of necessarily having a cook book and looking up what we do with one community and another community, I think that's often been the approach that people have taken. I think we have some basics in place and we have basic compassion and we understand and we ask how best to connect then we're going to get somewhere otherwise people are not going to come forward, they're not going to speak, they're not going to feel safe.

PROF WHITEFORD: I think - yes, (indistinct words). So the issue is, coming back to what Julie and Stephen asked, what can we say - what can we recommend concretely that should be different? If it's about, 'Let's just all be, you know, less, you know, discriminatory in how we deal with people with mental illness and their families'; so how do operationalise that? If we go to the chapters that make the recommendations around carers, we recommend reduce the barriers for access and income support, deal with the employment support issue, deal with family focused and care inclusive practising services and we've got things in there that we say we're going to do; what's missing?

So I'm not asking you to answer us now but if you could come back to us and say, 'Well, look, we think you, you know, you've said the right words', if we have, 'but we think the recommendation which should be in there which isn't in there' or 'the recommendation you got falls short because of this', then that would really be helpful because it's people who are close to the coalface of these services who can perhaps have more precision than we might have in the Commission.

MS PIU: I'm happy to do that. I think the main thing, and I'm sure the others from Mental Health Carers Australia would talk about, is the practice standards that are provided, for instance, the practical guide for working with carers and families but again unless you do that within a different culture of work, a different work culture, unless we shift the culture it won't be sustainable and I think it's a problem that we have around the country.

PROF WHITEFORD: Yes.

PROF KING: Just following up from Harvey. Also when, this is an old term, but the (indistinct) communities when thinking about recommendations for them. Yes, in some ways we've been quite high level in saying, 'Well, we don't want to specify what services are appropriate for this particular region which has - I live near Box Hill which is a very large Chinese community, the services that would be appropriate for that community are completely different to say North Brunswick/Coburg where it's an Islamic community, for example, because there are significant cultural differences in the appropriate to mental health under, you know, a whole range of issues.

So we've in a sense said, 'Well, that's up to regional commissioning bodies to work out what is best for the communities where they are serving'. But we being then - a number of people have said, 'Well, you haven't come up with recommendations for the (indistinct) community' and I guess I sit there and say, 'Well, we have. We've just tried to make it flexible enough to deal with all ranges of cultures and issues' so if there's something practical that we've missed I really would like, you know, if you could put your mind to what/how that should be phrased then I would really be very pleased?

MS PIU: I think codesign and coproduction it's what missing from there and so if I think about it, you know, again it's 'doing for'. I think we've moved beyond 'doing for' anybody (indistinct words) and I think there are members of all communities, whether they be Aboriginal, whether they be multicultural, who don't want to deal with culture specific services and they might want to come to a mainstream service for a whole lot of reasons and they need to feel safe to do that so we need to think about what that means.

PROF WHITEFORD: How the mainstream service can be safe, yes.

MS PIU: That's right, absolutely, so I think that - but I think codesign and coproduction again in the papers that we've developed in Victoria it's very, very clear how to do that and I think that we're trying to do that here and I think we can do it but it's about asking, 'What would you like?' so in Brunswick what does the community want? And the community is quite diverse in Brunswick so I think it would be a very interesting picture.

PROF KING: Thank you very much.

MS PIU: Thank you.

PROF WHITEFORD: Thanks, Marie.

PROF KING: Next we have Professor David Copolov and Professor Tarun - - -

PROF BASTIAMPILLAI: Bastiampillai.

PROF KING: Bastiampillai.

PROF BASTIAMPILLAI: Yes.

PROF KING: I have to ask, so it is Sri Lankan or South Indian?

PROF BASTIAMPILLAI: Sri Lankan.

PROF KING: And if you could state your name and who you're representing for the transcript and then if you could please make any opening comments you'd like.

PROF COPOLOV: Okay. I'm David Copolov, Pro Vice-Chancellor of Major Campuses and Student Engagement at Monash and Professor of Psychiatry at Monash and at the University of Melbourne but I'm not representing my university in regard to this consortium. Tarun and I are speaking on behalf of a consortium of psychiatrists and a psychologist, that's Associate Professors Stephen Allison, Geoffrey Waghorn and Professors Assen Jablensky, Vaughan Carr, David Castle and Bruce Singh. So we're sort of a chorus of individual opinions in psychiatry and psychology. Would you like me to make some opening submission and then for Tarun to speak?

PROF KING: Yes, Tarun, if you're just able to state your name for the record because need to be able to tell different voices apart.

PROF BASTIAMPILLAI: Tarun Bastiampillai, Professor of Psychiatry at Flinders University.

PROF KING: Thank you.

PROF COPOLOV: Okay, so first of all we would like to say that this is a most impressive draft report and covers a huge range of areas and we would, in our submission, which we'll be

providing 23 January will be providing comments on many of the sections. We are going to focus on sections 2 and 5 today and in the supplementary material that we provided which included the recent report from the Treatment Advocacy Center in the United States on the huge problem of boarding psychiatric patients in emergency departments in that country, the report commissioned by the United Kingdom on the need for at least 1000 additional beds in the United Kingdom and that's a country that has 90 number of beds than we do and also the impressive article from our group in the issue of Western Australia and the problems that have been associated with mental health services in that State as highlighted in the Western Australian Auditor General's report.

Since then the Journal of the West Australian AMA has highlighted that in the month of September 228 mental health attendees spent more than 24 hours in West Australian emergency departments with an average of 38.5 hours with more than 8800 hours being spent in the emergency department in that State in just one month. So we wish to address only a few of the areas because of time constraints. The first one is that although your recommendation 7.1 says that it is really up to the States and Territories to determine the level of service provision within the regions within their State and Territories and to undertake to provide those services.

It's our view that the general tone of the report is essentially that if you can avoid inpatient care that's a good thing to avoid and this is actually in keeping with the Australian overall philosophy towards inpatient care and I really want to emphasise that when we talk about beds we're not talking about pieces of hospital furniture, we're talking about the care; the high level professional care that comes with inpatient care. When Australia dropped its number of psychiatric beds from 30,000 in 1965 to 5000 in 2005 at a time when the population increased by 80 per cent there were many advantages to that reduction because of the fact that there were some poor practices in the larger institutions but this is a definite example of overshoot of reduction in beds and it's contributing very substantially to these high stress levels felt by consumers, patients, family members, staff.

The crisis that is very common within emergency departments, and although there's mention in your draft report of alternatives to emergency care, one of the alternatives that isn't given sufficient attention in our view is the need for more beds, both acute and non-acute. There is an emphasis in Chapter 7 on those beds being provided in community settings. In our view more beds should be provided as non-acute hospital beds.

The second that we'd like to address is something that didn't get into the draft report and that is the idea that there should in fact be the establishment of specialist mental health centres which are university affiliated in co-located general hospitals. As a Productivity Commission clearly your interest in issue such as economies of scale and yet in psychiatry mental health generally there has not been sufficient attention places on economies of scale that come with things such as hospitals and specialist aggregation of expertise.

If I could just say that I've spent 14 years as a director of public specialist hospitals in Victoria, nine years as director of Peter MacCallum, six as the deputy chair of Peter MacCallum Cancer Institute and five on the board as a director of the Royal Women's Hospital. The quality of care that's provided by specialist public hospitals in ONG and neonatal care and in cancer is just not provided in psychiatry. When I was on the board of

Peter Mac we were working towards and eventually there was a \$1b building for Peter Mac and there are 580 researchers there, there is a wonderful (indistinct words), there are huge numbers of clinical trials, we don't have that expertise and what's more we don't have the philanthropy. Peter Mac raises nearly \$50m a year in philanthropy. You don't get a lot of people donating a lot of money to mental health wards in general hospitals.

And finally, I'd just like to say in relation to your very important section on governance pulling the reforms together. Draft report recommendations 22(1), 22(2) and 22(4), the role of COAG, the possibly expanded role of the National Mental Health Commission, the creation of regional commissioning authorities; all of this is very important and the idea of introducing a national mental health and suicide prevention agreement and a new hull of government national mental health strategy is very important.

But it's interesting, a lot of what is happening both with the National Mental Health Service Planning Framework and the like are expectations, goals and aspirations and we actually think there should be more in the terms of requirements and one of the things in my recent visit to Germany, the German federal government has introduced a new law which sets minimum standards of the amount of time that is allocated per particular mental health professional per patient per week, this has actually been an ordinance since 1990 and is being introduced as a law is to begin 1 January so these are requirements rather than aspirations and we think there should be more requirements in terms of minimum service provision in whatever configuration of agreements and strategies are developed as part of the implementation of the Productivity Commissioner's recommendations. So I'll leave it to Tarun.

PROF BASTIAMPILLAI: Thanks for the opportunity to speak today. I'll be focusing on the bed numbers and the requirements from a modelling perspective. My context is I was a clinical director in a local service in Adelaide which is confronted by EDQ issues and supply demand mismatch so it's sort of interested in the bed numbers and the community resources that are required to address that kind of complex problem and then for the last years three in (indistinct words) for mental health services in South Australia asked to look at that problem at a State wide level and look at how many beds and (indistinct words) with interest Professor Harvey Whiteford's National Mental Health Planning Framework and (indistinct words) meetings around the modelling.

I guess at one level I looked at the OECD (indistinct) and we looked at the countries. Anglo-Saxon countries tend to be low, European countries tend to be high, the average is 71 so I was just interested in that number as a starting point, a normative kind of modelling. Australia sits at 42 of which 13 beds are private sector and there's a been a growth in private sector and the public sector's effectively been static at about 29 beds (indistinct) 1000 so I was interested in that as kind of almost like a social cultural phenomena, Anglo-Saxon versus European.

And my personal experience working (indistinct words) it was roughly 60/70 beds I never went to the ED, there was no queuing problem, we had good social services, I could admit directly to the ward and there wasn't so much residential facilities but I could easily admit to a ward so it was quite puzzled by what I was seeing in Australia but it was clearly from my point of view a supply demand mismatch. And the World Health Organisation has high

income countries sitting at about 50 and European Union sitting at about 50 so these are kind of what I would think as comparative benchmarks.

So the question is within Australia sitting at 29 beds (indistinct) is it right and can community investment prevent the need to increase acute beds or in fact decrease acute beds. From my point of view it's sort of like a tipping point. I think Australia's tried to reduce acute beds for the last 10/15 years and has been unable to do and there has been increases in community investment and I note with interest your graph which showed the community investment growing up until the last five years where it's static but (indistinct words) primary care stepped in and big resources have gone into psychiatric depression but if you look at the codes that are coming to our ED departments they are crisis patients with anxiety, depression, drug and alcohol so when I look at the ATAPS and Better Access program which is meant to treat anxiety-depression I'm puzzled by the numbers coming to ED with anxiety and depression so more of ATAPS and more of Better Access I'm not convinced will register a signal in the ED and therefore when I'm on the frontline with 20 people in the ED with anxiety-depression what is the solution in the short term (indistinct words) long term.

So in terms of our consortium we put together a kind of framework bearing in mind national mental health (indistinct words) has quite sophisticated algorithms that drive it. Our numbers for general adult, and I think in your document a helpful sub-analysis (indistinct words) because the quantum are different and the needs are slightly different so on general adult the national average is 24.5 acute beds, our proposal suggested 30. For non-acute beds the national average is 9.5, we suggested 15 - effectively a 25 per cent increase. And with residential beds the current Australian average is 10 and we suggested 20 so our net was about 65 and the current average is 44.

Now, I guess there's a semantic issue about non-acute beds, we're in agreement about the need for non-acute but the question is should that be in a community residential facility or a non-acute inpatient ward and I think that that's an ideological question, a practical question, a policy question and there's concerns about what a non-acute bed represents from historical terms but again about the scale, the economies of scale, there's some advantage in having rehab precincts where you get core location of expertise.

So I think our modelling, we're not convinced that community residential can substitute for the acute and non-acute to the extent that's inferred in the Productivity Commission documents. That's probably our only major point of difference about residential. I've had practical experience of running residential and the kind of patients that can go to residential facilities are quite different than what we see in acute and non-acute and to be honest it's psychosis with intellectual impairment with drug and alcohol issues and with potential progression and when you've got a small 20 bed unit in the community the occupational health and safety issues present a problem in terms of realistically managing this in a community setting. So, thank you.

PROF KING: Okay. I suspect Harvey's going to want to first question, so.

PROF WHITEFORD: Right. So I think if you look at the recommendations in the draft report where the modelling to date, and this is a draft report, was a small increase in acute beds and large increase - and 80 something particular increase in some acute/non-acute beds

and we can debate where those beds should be but I think why are we recommending a higher increase in acute beds I guess is the biggest issue and there's two issues for consideration there from I think the Commission's point of view, the first is that the submissions we've had and the people we've spoken to, when we've gone to acute units and we've asked, 'Do you need more beds?', the answer is, 'Yes, we need more acute beds' and then we ask, 'Well, of the people who are in your ward now', and you've heard this many times, 'who don't need to be here or could be discharged or wouldn't have needed to be admitted, how many?' and the answer to that is somewhere between 20 and 35 per cent. So the pressure then is to try and address that and, you know, allow people not to be admitted because there's alternatives in the community or there is, you know, options that allow earlier discharge.

Now, the length of stay in those units is shrunk and shrunk so I certainly agree that the length of stay now is very short I think clinically so I'm not sure that shrinking it further is necessarily going to be that therapeutic and that the length of treatment in those units is maybe better provided of what the patients need in non-acute beds or longer term inpatient care. So it's about that balance. What you're saying, Tarun and David, and correct me if I'm wrong, is that there may be some evidence that the provision of those community alternatives, although as you point out it's plateaued and in some places like Victoria it's gone down, hasn't taken the pressure of the acute beds or the need for acute beds and I guess that would be something we would like to see (indistinct words) and to consider for the final report.

PROF COPOLOV: So in your report you've highlighted the fact that it seems to be a paradox but it's not, that there's both premature discharge and delayed discharge. The delayed discharge is because there aren't sufficient non-acute beds and (indistinct words) suitable, the premature discharge is that we are discharging the least unwell not people who have fully recovered. Now, it's our view that when you have a system as we have in Victoria where it's mainly risk management and only admitting people where the threshold to be admitted is that you have to be a danger to yourself or a danger to other people is such an incredibly inappropriate threshold. It is totally inappropriate.

This is where we want people to understand that there is a value in inpatient care. Only a small proportion of people need inpatient care but when hospitals, I'm a great proponent of hospitals when they're needed. If you've got sepsis, if you've got spinal trauma, if you've got a myocardial infarction, hospitals are good places. If you've got a severe psychosis where you are out of control and you're a danger to yourself or even if you've got severe depression and you're not suicidal but you've got terribly treatment resistant depression and you don't happen to have private health insurance you should be able to go into a hospital.

I've just come back from Germany where the compulsory admission rate of the patients who are admitted is closer to 6 per cent rather than 55 per cent in Victoria so we have first of all to reduce the bed occupancy rate from 95 per cent to 85 particular, which is a recommendation, to reduce the threshold so that you don't have to be a danger to yourself or others to get into hospital and so you can have lengths of stay where you can actually recover. All of these things require, in addition to non-acute beds, require increased acute beds.

PROF BASTIAMPILLAI: I'd agree. Just one added point. The logistics of (indistinct words) governance, I think that some acute sectors are not linked with the acute in community sectors so there's kind of inefficiencies, it's a logistics problem going from community to ED to sub-acute and you're seeing four psychiatrists where in England where I worked I managed everything. I was almost like a village psychiatrist, I knew the 20 GPs, the GPs would give me a call, I'd say, 'I'll see the patient tomorrow', I'd admit to the residential facility and/or the inpatient facility but that was England.

London is a village and I operate as a village psychiatrist but here it's suburbia and I operate in a silo so I think one of our problems is not the resources but how to integrate resources and how do we have governance at the very local level. I saw your statements about governance at the top level which I sort of agree with, a complex problem, but how do you replicate the English model where I can chat with the English GP and organise an appointment within a minute without an incentive structure and I was on a salary.

PROF WHITEFORD: Sorry, can I just follow up on exactly that point because (indistinct words) a question that I wanted to ask which is the interactions between the beds that - you know, it should be a smooth flow of the patients/consumers between the different settings (indistinct words) settings. So it would be good to get more details exactly about how it works under the NHS, which I assume is - - -

PROF BASTIAMPILLAI: Yes.

PROF WHITEFORD: And our approach through the Regional Commissioning Authorities in a sense was an attempt to look at a body that was able to bring in that sort of coordination so you may still have in a sense a hospital with a silo but it's the commissioning authorities' job to be making sure that the lengths of (indistinct words) acute/non-acute community beds so that you don't - you know, you had that linkage up with the services. Your thought on that, your thoughts on what different that sort of linkage would make then to the sort of analysis you on had beds?

v COPOLOV: So, in our - sorry, do you want to - - -

PROF BASTIAMPILLAI: (Indistinct words) talking I believe in linked datasets so if you have an acute/non-acute GP that first step is the linkage to the datasets, that's the first utopian position, or dystopia in some people's - - -

PROF KING: (Indistinct words) viewed that as, you know, why we can't do this - - -

PROF BASTIAMPILLAI: Yes, so that would be the starting point, that's a Scandinavian kind of idea. The second step is that I as a psychiatrist in an ideal world will look at a consumer in a holistic fashion no matter where they are and that the governance and the organisation between me and the GP's link and that customer is both the patient and the GP so I need to have 20 GPs in my patch and I service the training needs, the (indistinct) of the GP and then that a seamless integration on the one care plan which is under governance of a psychiatrist and an MDT team working holistically for the patch.

However you define the patch; Coburg, Brunswick, Box Hill and the Box Hill might be more Chinese and Coburg might be more Islamic et cetera so then you'd liaise with the right sociological infrastructure with a linked dataset. Now, that is possible in NHS and the governance of the NHS is integrated and the structure of the NHS is integrated at that local level. I think Australia will struggle to do that; hence we've got mental health commissions, state bodies, chief psychiatrists, planners, national mental health plans, universities. It was very, very simple in the English model and to some extent I'd love it if we could replicate that local planning.

PROF COPOLOV: So a larger consortium of us put in a submission that you received called the Adults Psychiatry Imperative, and within that submission is a detailed section of what we've called mental health integrated service hubs, which are based on the integrated (indistinct) which are in Victoria, which includes the components that you so rightly emphasise in your report about navigating. It's so complex for people to navigate the various opportunities to be involved, not only in the medical services sector but also housing and legal advice and the like, so we were recommending that there should be an integrated hub which maps to what we're calling mental health networks which are similar in geographical areas to the PHNs that could enable people to be linked via hospital to GPs, to private psychiatrists, and in your report you've highlighted that the private sector really needs to be brought into this whole issue in a major way, so the need for integration is something that we consider very important, and then the question is, as you addressed in your report, who at what level should be the commissioning agency should the integration be responsible for because we do have the Commonwealth and state having different responsibilities.

MS ABRAMSON: I had a very general question. Mr Copolov you made a really interesting - you made a lot of interesting comments, but you made a really interesting comment about how the resources aren't in mental health or the philanthropy in the way they are when you were at Peter Mac, so what can we do to change the community discussion around this so that we say that people are asking for, one, that type of service that you're talking about and we can get the type of models that we have, for example, at Peter Mac with cancer care?

PROF COPOLOV: So it has a lot to do with the destigmatisation that you've addressed in your report, but it also - having raised a lot of funds both for the mental health research institute when I was director for 19 years, and also subsequently for I've been on the foundation board of Peter MacCallum. These are highly professional organisations. They require extremely dedicated people. They require data sets and networks and I think - and organisations, and this is why I'm saying, for example, if we had a Peter MacCallum or two or three Peter MacCallum equivalents in each city and we had some rehabilitation centres as well, we could attract the staff who would then focus on the highly professional task of raising funds.

So there are organisations in Australia like Mental Health Australian, Beyond Blue, Orygen. They raise funds, but you need a significant size of organisation and you need a dedicated fundraising team.

MS ABRAMSON: To get back to your point, though, how do we get there from where we are now? Like, what sort of recommendations would you have for us?

PROF COPOLOV: Well, I just go back to my point that there is an anti-aggregation - it's very interesting talking to the Productivity Commission about lack of economies of scale, but we don't have - we have a sort of a - what happened when the institutions and old hospitals were closed is it was very good. They had economies of scale but there were some very poor things about them. But now we've gone the other direction where you've got it distributed to too many different sections, so you don't have centres of excellence, so I think that's an important element.

PROF WHITEFORD: I'm just going to squeeze this in before we finish.

MS ABRAMSON: I see your beady eye.

PROF WHITEFORD: Yes, well, we could go for a long time. We probably should, but can I jump to the point you made about the minimum standards of care for time allocation from the German work you've seen. I've read your submission. The references are in German and I assume that could be written in German, so it would be good to get them in English. But one of the things we have identified in the report, which is of significant concern, is the efficiency of the community mental health service. This is the public sector community mental health service. There's an activity-based funding which often drives the inpatient services, which has its own problems, but at least it's there. In the community services as they currently exist in the states and territories, they're largely block funded, and the data we've got suggests that there's nothing in the funding of those services that drive efficiency or increase productivity and that the time spent by FTE equivalent clinicians in those services is often much, much lower than we would like and certainly much lower than, for example, is in the national service planning framework. Anything that you could show us or suggest from the German experience that you've mentioned in your documentation or other information you might have about how other governments tackle that would be gratefully received.

PROF COPOLOV: Okay, so it's very important because in your draft report you highlighted that face to face contact of community health service is only about 30 per cent, so there could be a significant improvement by reducing administrative burden on community mental health workers, I think, as well as increasing community mental health and the like. That's why in the new Psych VVG there is a - - -

PROF WHITEFORD: Sorry, that is the - - -

PROF COPOLOV: That's the new law, sorry, for - - -

PROF WHITEFORD: In Germany?

PROF COPOLOV: In Germany, coming in on 1 January. There are requirements for quality as well as time, so you're right. It's just spending time may not be sufficient. So we'd be very happy to provide that.

PROF WHITEFORD: That would be very good to see. Thank you.

PROF BASTIAMPILLAI: Harvey, I'd just like to respond to that. Having run and managed community mental health centres, I was puzzled by the lack of face to face time. If I was a GP or in private psychiatry it would almost be a bankrupt business. If you converted that all into fee for service, it wouldn't meet the fee for service test, so I always thought about whether fee for service would work in community mental health, and then the other point is gaining or seeing people that may be less complex, and you traversed that in the document.

But I think community mental health is not actually aware that their times are that low so I think benchmarking and that we should benchmark, say, North Sydney face to face time 50 per cent, Flinders Medical Centre face to face time 10 per cent, and that already starts to put me on notice as Flinders Medical Centre, so I think that's an important point about benchmarking which is covered. We need to make that clear to community mental health, that there is a standard, whatever that standard may be. I think it's realistically 50 per cent, is my view, but the administrative burden and the logistics and risk management may be community mental health but almost become like an insurance industry, checking on risk, but checking on risk versus addressing risk are two separate things.

I think community mental health is very scared about suicide, and in that context there's over-emphasis on risk management, and that has lessened the effectiveness and efficiency of community health.

PROF WHITEFORD: What you're implying there is that risk management results in more perhaps bureaucratic documentation to try and cover activities which takes away from time that clinicians might spend with consumers.

PROF BASTIAMPILLAI: Yes, yes, I think so, and I think that the data and the linking of the data would also help community mental health, and attaching ED avoidance to community mental health matrix, so if you're in the region in the community I would say your ED rates of anxiety disorders are - compare to the benchmark, so I'd attach hospital KPIs to the community. At the moment they've been disconnected. So if I'm going to set up an anxiety disorder service in the community, I would set some efficiency benchmarks and I would also say, 'Did you reduce panic disorder presentations to the Royal Adelaide Hospital?'

PROF KING: Thank you very much. Thank you. Next, we have Andrew Marks. If you're just able to state your name, affiliation for the transcript, and then if you'd like to make an opening statement.

MR MARKS: Sure. Good afternoon. My name is Andrew Marks and I'm the director of counselling and mental health programs at Monash University and my very good colleague, Professor Copolov, asked me if I could put together a response to your draft recommendations on behalf of the university, so to some extent that's what I've done, although I'm sure I've missed bits and pieces here and there.

So I really appreciate the opportunity. I'm not sure if you've had any presentations from other universities, but I've been at Monash for 27 years and I've seen a tremendous change in the sorts of presentations that we have seen in through the counselling service from when I started, and I suppose there is a fundamental question of why do universities have

counselling services, and I know at Monash they first established theirs in the late 60s I think.

My view about that is that our role is to support students in attaining academic success, and so when I started back in 1992, a lot of the sorts of presentations I was seeing were, 'I'm not sure if I'm in the right course,' you know, 'I've just broken up with my girlfriend,' relationship issues like that, and they're of course still a lot of what we do see coming in, but what I've noticed, particularly in the last 10 years is a significant increase in the severity of presentations, both in our local population and our international student population, to such an extent that during teaching semester time we'd be needing to get a student to hospital by ambulance probably once a fortnight, so that's the really pointy end of the work we do.

Just to give you some statistics maybe to talk about that first, so this is from Monash's 2018 publicly available statistics, we have 72,600 odd students on our Australian campuses, so my role just covers the Australian campuses. We saw some 6,018 students came in to use our services, which is 8.3 per cent of the total student enrolments. One of the points you make in your draft recommendations around full-time equivalent ratio of counselling staff to student population. It's great to have a look at that, actually, because I hadn't looked at it for a couple of years and Monash is now at 1:2,500, a little bit - so that's quite remarkable because last time I looked at that we were about 1:4,000.

We've had a significant restructure - two restructures really - in the last seven years, which has enabled us to bring that ratio down and I think increase our overall productivity and capacity to meet the ever-increasing demand of students wanting our services.

So I just want to explain what we've done. The traditional way of engaging psychologists at university counselling services is as employees. We were just finding that we weren't able to meet the demand and so about six, seven years ago we introduced workforce to sit side by side our employed staff of private psychologists working under Better Outcomes using Medicare, so obviously they need a referral from a GP, but we've got a comprehensive health service, so our GPs can write those referrals and we're all co-located in the one building. So that, without any real cost other than providing a room, increased our capacity quite dramatically.

Probably three years ago we introduced a third model, which was not using Medicare but engaging a workforce of psychologists working privately still for themselves but contracted to provide those services to the university and then the university pays them directly.

The advantage of those two additions to our workforce is that those two groups, the Medicare and contractors, just do clinical face to face work, and what we pay the contractors per hour of consultation is exactly the same as the Medicare item number for that service that's paid by Medicare to the Medicare psychologist, so there's no differentiation and there's no cost to the students. It's a free service.

And it's a free service also - one of your questions in the recommendations was around health insurance for international students, so I just want to talk a moment about that. There's a number of companies that provide health insurance to students studying from overseas. I understand it's a requirement of their international student visa that they have that insurance now. There was a time when it wasn't, which was really problematic for very ill students, but

we've moved past that.

For Monash's situation, our preferred supplier is Allianz but the student is free to take up whatever company they'd like to. The reason I mention Allianz is because for students that have chosen them, when they come into our health service they don't have to pay an upfront fee because we've got an arrangement where we can just bill Allianz directly for the GP consult or the psychologist consult, so all the time we're trying to lower the barriers to access of our services.

For students with other health funds, they have to pay but they'll get 100 per cent refund for that. It's my understanding that the health insurance providers mirror the Medicare item numbers and the dollar amounts attached to those, so that if we're bulk billing the students aren't out of pocket and that's really important.

Where we do have a problem for international students, or where they have a problem, is if they are needing to attend emergency departments. What we've found in the last few years is - and I think it's now universal in public hospitals - emergency departments are charging an upfront fee when an international student presents to the concierge, and that can be in the range of \$600, and sometimes that's prohibitive. So we might have a student that needs to go to hospital, we might have spoken to psychiatric triage and they recommend that they get the student down there and then they're confronted with this upfront fee.

Again, for our students, we have Monash Medical Centre and the Alfred which are the two major hospitals closest to where we are, our major campuses. The concierge can ring up the health fund and they'll pay for that over the phone, so again, the student is not out of pocket.

But as a general principle, that's a significant problem, I think, for these students that are disadvantaged anyway and that is an enormous amount of money for them to try and find to pay upfront.

Just on our international students, I think there's a general perception that - so a lot of our students come from Asian cultures. There's a lack of willingness to engage in mental health services. What we've found is at our Clayton campus - this is based on last year's figures - 30 per cent of our enrolments at our Clayton campus were international students but 33 per cent of our patients coming through into the counselling service were international students, so they're slightly overrepresented, so it kind of goes against that general perception that they're reluctant to access mental health services.

At our Caulfield campus we've got 62 per cent of our enrolled students at that campus are international and they comprise 50 per cent, so they're a little underrepresented at that campus, but they still make a significant proportion of the students that we see. Unfortunately, they often come later rather than earlier and often they're sent by academic staff and so unfortunately if they'd sought treatment earlier they may not have got themselves into such a dire situation.

So it's interesting with that model. We've got three different types of engagements. At the moment, we've got 29 FTE of psychologists working in the service, 10 are employed staff, seven are Medicare under license and 12 are contracted.

I just wanted to mention one thing to keep in mind regarding the ratio. There's a lot of talk about the ratio of counsellors to population. The ratio is important to look at but it's also really important to look at what are those staff doing between the time they come to work and go, because one of the ways we've been able to increase our capacity is by having these dedicated staff that are just doing clinical work, and they're for the most part not full time, so they're maybe seeing six, seven students a day, whereas our employed staff actually are running a lot of our mental health programs and so when they're not they're probably only seeing five staff a day, so in terms of efficiency, we found this model to be enormously beneficial to just meeting that constant demand for walk in and phone call appointments.

I feel like I'm going on. I've got a few more things to say, but - - -

MS ABRAMSON: No, no, it's been great. Thank you.

MR MARKS: I'm welcoming of any questions. I've got a little bit to say on some of your recommendations around staff training, so do you want to - - -

PROF KING: I was going to ask you a question about that.

MR MARKS: Yes.

PROF KING: So thank you. At the moment, lecturer As, for example, who have quite close contact with the students would receive training in general on teaching methods and so on, but as far as I'm aware no specific training on the mental health of students, how to recognise students that may be under stress. Going through from there through to, say, PhD supervisors. I know Monash has a PhD supervision requirement, training, although many academics are grandfathered from that. Again, I'm not sure if that has any issues relating to either recognising mental stress or students or issues of bullying or potential bullying so that the supervisors can be aware of their own conduct.

So I'd be very interested to hear what your views are on the needs or otherwise to increase mental health awareness, mental health training right through that workforce from literally the lecturer As through to the level Es and the post-graduate supervisors and so on.

MR MARKS: Sure. How long have we got? I provided the Commission prior to today with a copy of our mental health strategy, so Monash developed that back in around 2012, 2013, and I think it's on p.4 there's a pyramid which sort of graphically shows the different levels of that strategy. The third level is mental health literacy and that's where this training comes in. So there's a very significant need for training academic staff and professional staff as well in recognising the presentations of mental stress, mental health problems, and knowing - not just recognising, knowing how to interact with the student and then knowing what their limitations are and how to help that student get the support they need, and there's two maybe obvious reasons for that. One is for the student's wellbeing and one is for the staff's wellbeing.

So we run a range of mental health literacy programs for staff in the university and have done for many years. There's a 12-hour program Mental Health First Aid which I think you

mention in your recommendations, and we've initially started back in 2007 running that for staff, and I think in 2005 or 6 there was a Senate Select Committee report which briefly talked about Mental Health First Aid and recommended that 6 per cent of the workforce, particularly with roles where they're interactive with the public, undertake that training, so we thought, 'Well, we'll adopt that at Monash.'

We charge staff for that, and we've recently - or not that recently; probably about six years ago - made it available for students and about four years ago made it free for students, and now we train far more students than we do staff. So the point of that, that rationale for that is that peer to peer support is crucial in getting early connection with mental health professionals if that's necessary.

PROF KING: Just on that, are the actual staff interacting directly with the students on a day to day basis, and I'm thinking of the educational staff. Six per cent sounds a very low number to me. I mean, I would have preferred a number like 100 per cent.

MR MARKS: That was back in 2007. We have moved on - - -

PROF KING: Is there compulsory - I'm not sure across every faculty, but certainly a faculty that I know quite well, no tutor ever got in front of a class until they had had basic training, and there was I think a two-day workshop that they all had to do on teaching methods, interacting with the students. Now, from memory there was no mental health training in that. The real question is, should there be?

MR MARKS: Yes.

PROF KING: Okay.

MR MARKS: Yes, there should be, and one of the problems we've had is that a lot of those tutors, especially at the undergraduate level, are often post-graduate PhD students, they're employed as casuals and so faculties have been reluctant to pay the hourly rate for non-core training, so we did a - we got some money about eight or 10 years ago and focused it on those tutors because they're often the first point of contact that undergraduate students have with academic staff where there's an emerging mental health problem, and it's usually when they're asking for an extension and the tutor might say, 'So why do you need an extension?' Now, that question can often open up everything. 'Well, you know, this is -' so we wanted those frontline tutors to be trained in the mental health literacy and knowing what the services are that are around at the university and how to help facilitate those referrals to professional help.

We found that the 12-hour program was a bit of a barrier because it's a long program, so we've had requests across the years and we've created a cut-down three-hour version that we run for those tutors now and we still want staff to do the 12-hour program but the answer to your question, yes, I think it would be compulsory for tutors. Now, I'm not big on compulsion, but increasingly it's seen as relevant necessary training for academic staff to do their job. It's not an onerous amount of training. You know, three hours is not really asking too much, and I think if staff are viewing that as a way of helping them to do their job, there's probably going to be a good uptake.

PROF KING: I'll look to my colleagues because they know I could go on about this all day.

MS ABRAMSON: No, I'm happy to allow you to, Stephen. You may not be able to answer this, Mr Marks, but when we had some of our earlier consultations students said to us, 'Well, it's all very well that you're talking about support for mental health, but actually the academic side of things was not flexible so I needed to drop out of university because I couldn't actually get a leave of absence for mental illness,' or 'I couldn't come back on a part-time or sessional basis.' I'm just wondering - you talked about mental health literacy for the staff - how you're making - and I am an ex-graduate of Monash - how you're making the clunky university processes responsive.

MR MARKS: One of the areas is special consideration. That's really what you're talking about.

MS ABRAMSON: Yes.

MR MARKS: So I sit on - there's a university-wide special consideration committee which is quite bureaucratic but they're doing their best. I sit on that committee and advise them.

It's an issue of bureaucracy to - one of the things with this updated strategy that I sent you, and we updated it in 2018, was to make it a whole of university strategy. Prior to that, we called it a whole of university strategy but it was really the counselling service strategy, and so one of the things we did was spell out in this new updated strategy what's the responsibility of the health and counselling services and what's the responsibility of the whole university? So I would see the special consideration bureaucracy, just to take one area, is where the whole of the university needs to step up and consider the mental health implications of decision that they're making.

Not particularly do anything differently unless they can see that they're making a decision where an unintended consequence is to damage the mental, health of their students, and an example of that was - which we were able to change quite easily, was the university used to release semester results on a Friday afternoon. There's no services that we can provide that are available over the weekend and I pointed that - and it's actually quite a risk for students that are vulnerable, and so we were able to have that discussion with examinations and they're now released on a Monday morning, Sunday night if you've registered for SMS. But that's just one example of where we try and work when, from my point of view, I can see an issue which would be relatively easily fixed.

But you're absolutely right. I mean, the students that gave you that feedback are correct in saying that often the bureaucracy can get in the way of having good outcomes when it's not necessary for the bureaucracy - you know, the university doesn't lose anything by being more flexible. It's just often they're unaware of it.

So my answer to that, it's about cultural change, it's about increasing awareness of the people in the faculties and elsewhere who are making these decisions and these policies just to consider the potential mental - just ask the question, 'What are the potential mental health consequences of this decision?'

Another one is where progression is affected to the point where students are unable to - are no longer eligible for Centrelink, because financial stress is a huge component of emerging mental illness. It's not on its own usually but it's a component. So that's what I could say really in response to that.

MS ABRAMSON: That's really helpful. Thank you.

PROF WHITEFORD: I'll ask another one. You mentioned the counselling services when you started were, you know, really services for academic success and that the severity - the issues have changed over time. One of the questions we've asked of all institutions for the workplace, for schools, tertiary institutions, is really if there is a functioning and a well-operating in-community mental health services, do they need to be replicated? For example, we suggest wellbeing leaders in schools that can act as links in the community, not psychologists in schools. We've got similar linkages in the workplace. Universities seem to be slightly an oddity in that as you've said you have your own counselling services, some of which look like community services. You mentioned the Better Access program, but at the same time you also have psychologists on a contract basis.

So I'd like to get your views about whether a better way - if you were starting with a blank sheet of paper, would you go to the situation that you have now at Monash or would an alternative, and I'd be interested to know if you'd view it as a better or worse alternative, be that Monash would be an effective gateway into non-Monash community-based services. Just your views on that and which way we should be thinking about in terms of our recommendations.

MR MARKS: So I wouldn't - I think the model of having on-campus services is really important for access. Not just convenience, but - in fact not particularly convenience. If you imagine yourself as an 18-, 19-, 20-year-old with emerging anxiety or depression and you've never accessed any professional help before and you begin to feel like you're not coping too well, it can be quite frightening, just within yourself. You think, 'What's going on with me?'. So to try and facilitate access as easily as possible and lower the bar as much as possible, I think the on-campus services are essential, and often students will come in minimising why they're coming in and it will be - they'll say something like, 'I want some tips on time management.' But by 40 minutes into the session it emerges that there's some really quite profound underlying anxiety or depression or both.

So it's not so much stigma, it's fear, I think, that's the barrier. That's one thing. It maybe answers part of your question. The second question is our linkage with external agencies, and that's, again, one of the tiers in that pyramid in our mental health strategies, and where - universities exist within a larger community, obviously, and we're not trying to replicate. In fact, we rely on the external mental health services and hospitals that are available, particularly as we're seeing this increase in severity. Like acute presentations, but even chronic presentations that are beyond the capacity of our service to see, they may need, you know, weekly appointments. We do have a psychiatrist who bulk bills but he's just closed his books for the rest of this year because he's overwhelmed and he's not full time.

So we need to have access to those external - it's a collaborative relationship that we have with the external services. If anything, what we find is - and I'm sure you've heard this a lot

and I know you've written about it in your draft report - is the difficulty of getting acute illness treated effectively in the public system. So what we find is we may get a student that site triage says, like I said earlier, 'Get them in a taxi, get them down to ED.' But they'll be seen by a registrar, usually not admitted and sent home again knowing in their minds that they've got access to a fully functioning tertiary health service, and these are often quite acutely suicidal students.

If they're presenting with - there seems to be much more willingness to admit a psychotic presentation than a depressed presentation.

MS ABRAMSON: Can I ask one final question, and happy to take this on notice if need be. Do you plan to evaluate your strategy, or do you have any data or evidence on its effect?

MR MARKS: So it's a 2018 to 2020 strategy. We will definitely be evaluating it. It's difficult - I mean, we have an online automated quality feedback questionnaire that all of our students that use our service get once after their first visit. We do quality feedback from our participants in our programs but that's a very small part of what the strategy is. So how we go about evaluating this - I mean, it's very difficult to look at cause and effect. You can look at retention but then there's many, many factors that come into retention and I've never lay claim to an increase in retention being a direct indicator of the effectiveness of the strategy to be awareness. The number of referrals that we get. So we have to come up with a set of measurables, I suppose, that make rational sense as indicators of the effectiveness or otherwise of the survey.

MS ABRAMSON: No, I understand. Thank you.

MR MARKS: Yes, of the strategy, I mean. Yes.

PROF KING: Thank you very much.

MR MARKS: Okay. That was it? Are there any other questions?

PROF KING: No, thank you.

MS ABRAMSON: No, thank you. Thank you very much.

MR MARKS: Okay.

PROF KING: Next is Andrew Morgan. All right. Treat this as a submission and if we can get an electronic version, that would be fantastic.

MR MORGAN: Sure. I didn't bring the electronic version.

PROF KING: No, if you can send it through though, it will help us. If you could state your name and if you're representing a particular group, that group, and then if you'd like to make any opening comments.

MR MORGAN: Thank you. My name is Andrew Morgan. I'm making an individual

submission. I hold a certificate in psychiatric nursing and a degree in nursing and have practised in the area of mental health nursing for over 30 years. I've got extensive experience in the area of adult acute mental health nursing, predominantly in the emergency department over the last 10 years. I'm a longstanding member of the College of Mental Health Nurses and I'm also a member of the ANMF.

I wanted to clarify the setting in Victoria for mental health nurses if I could. Within the public sector, similar to South Australia, the EBA sets education standards for registered psychiatric nurses. To work as a registered psychiatric nurse at a level 3 you need to have undertaken training in mental health nursing or be progressing post-graduate training and at RPN 4 level you need to have had undergraduate or postgraduate training in mental health. Most private settings have similar expectations.

Whilst there is much to support in the draft report, I wish to talk against the reports draft recommendations no. 11.3 with respect to the undergraduate mental health nursing training and the separate mental health nurse registration. The report argues that the number of mental health nurses practising in Australia in GP clinics, community health services and the aged care facilities should be significantly increased, and I don't disagree with that expansion.

However, the report highlights that the only way to grow that workforce is to introduce undergraduate training and separate registration. It somehow sees this as a way to change what it sees as a poorly valued profession into a highly valued profession. It has a perception that the current mental health nurse-force lacks training. I disagree with both recommendations and believe that the status quo with respect to training should be maintained and expanded.

In my view, the report provides no or very poor evidence to support the recommendations and I will talk to three points with respect to that.

The draft report's graph, figure 11.5, reports to list those nurses with specialist mental health nursing qualifications is incorrect. The report wrongly assumes that only credentialed mental health nurses and those nurses where solely qualified in the area of mental health nursing via APRA, and they're essentially the migrant UK mental health nurses, as the only nurses with mental health qualifications.

The reality is that most of the nurses with mental health nursing training are registered as RNs only and so it won't show up on any statistic as having specialised training. To support this view, in the acute community team where I work a search of the Nursing Board database reveals that of the 40 permanent mental health nurses on staff, 28 have mental health nursing qualifications. Of those, 20 have undergraduate training and 8 have postgraduate training and five are overseas trained with mental health training. All are listed in APRA as RNs. Although all would be eligible to apply for the College's credentialing, only one has. None of the overseas trained nurses have the notation 'solely qualified' in the area of mental health nursing on their registration. What this shows is that only one of the 28 nurses on my team who fit the criteria as a mental health nurse will be listed on the graph shown in the report. Simply put, the graph doesn't show a complete picture of those specialist qualifications and I would suggest the graph massively underrepresents the number of specialised mental health nurses in practise currently.

I wanted to talk to the Australian College of Mental Health Nurses submission to the Commission. The draft report appears to rely heavily on the submission from the college and envisages a prominent role for the college with respect to workforce planning and training. I wish to point out that the college has no legal entitlement with respect to establishing standards of practice for mental health nurses. They don't govern practice in the same way as the various medical colleges do. I am concerned that the college's preference for credentialing led to a bias in the data it provided. The data supplied by the college on figure 11.5 only shows credentialed nurses, not the 1500 or so other mental health nurses that are members of the college.

I am also concerned about the inconsistency in the college's direction with respect to mental health training. The college's submission argues that nurses employed in mental health services should be appropriately qualified. That is, they should be registered nurses who have postgraduate mental health nursing qualifications.

But at the college's recent AGM two motions were put up which contradicted the college's submission to the Commission and coincidentally directly supports the recommendations in the draft report. Motion 1, to create a separate mental health registration, won by a show of hands. Perhaps a 60/40 split. Motion 2, undergraduate mental health nurse training was defeated by, I think, two votes. Only approximately 250 of the 3,000 members of the college that were eligible to vote voted. Hardly a glowing endorsement of the motions or of the report's recommendations in 11.3.

The Commission should also note that the college is currently without a CEO, and as a consequence almost half of the paid staff have resigned from the college.

I wanted to talk to the report's mention of a UK model of undergraduate mental health nurse training. The report essentially highlights its success. However, this appears not to be the case. With the MHS, mental health nurse, workforce down by about 6,000 in the past 10 years, with difficulties being experienced with worker burnout and recruitment into undergraduate training. I support the maintaining of the status quo. In my view, mental illness and physical health are clearly linked. It could be argued that the crisis to mental health care is because of a chronic attitudinal and funding disconnect between the two. In this context, a mental health nurse needs a physical health knowledge that comprehensive undergraduate training can provide. As a profession, nursing wouldn't benefit from the forced separation that separate training and registration would lead to. It risks the attitudinal gains that are apparent in the current nursing workforce.

Those that seek undergraduate mental health nurse training have not been able to demonstrate that it would create a cohort of new graduates into the field. The report doesn't provide any research that supports this notion either. Recent research suggests that there are actually an increase between 2013 and 2017 in the supply of mental health nurses from 8.3 EFT to 8.6 per 100,000 of the population, not a decrease, so something is working.

In my area of mental health network, of 149 graduate nurses commencing in mental health programs for the years 2013 to 2017, 30 per cent have gone on to complete postgraduate studies in mental health within two to three years.

I understand there was little difficulty in attracting new grads to work in mental health. We need to continue to provide and develop new support mechanisms to encourage this group to complete postgraduate training and continue into the mental health field.

Consideration should also be given to funding a program that would provide a wage to those undertaking a full-time postgraduate diploma and embed them into community mental health services. In Victoria this could easily be an expansion of the existing community training positions already in existence.

I'm happy to take any questions.

PROF KING: Okay. Thank you very much, Mr Morgan. Just a first one from me and then I'll pass over to my colleagues. Is it your view - so I note that you've said there's been an increase in the number of mental health nurses per 100,000 population since I think it was 2012, 2013 period.

MR MORGAN: Yes, yes.

PROF KING: Is it your view that there are enough mental health nurses, that we're in a pretty good situation, that the flow-through of new graduates is looking pretty good? So that's the first question, so I'll let you answer that one.

MR MORGAN: Sure. Okay, no, there isn't enough.

PROF KING: Okay. In which case - I just wanted to check before I went to the second part of the question, which is, well, that was our view in the draft report and so we were trying to think of ways to increase the number of mental health nurses, and you've suggested that we've gone down the wrong track.

MR MORGAN: Yes.

PROF KING: And thank you for your submissions to us. But then what would be the alternative? What should we be recommending to increase the mental health nurse workforce?

MR MORGAN: I think you need to look at the current model and improve on it.

PROF KING: Suggestions for how to improve on it?

MR MORGAN: Well, one of them is my suggestion in item 4 at the end, so you could in fact provide a wage to undertake a fourth year in nursing, remembering that nursing is a three-year course, not a four-year course like our allied health colleagues, so you could introduce a fourth year, which specialises in mental health, and you could somehow link that to clinical mental health centres as some kind of graduate entry program, for instance. That hasn't been tried, to my knowledge.

PROF KING: We heard during our inquiries as part of leading up to the draft report, we

talked to both teachers, we talked with a number of mental health nurses, including some recent graduates. It was put to us that one of the major pushbacks on more mental health nurses is that there is stigma within the training and within the profession towards mental health nurses. For example, it was put to us by a new graduate that they were told that going into mental health nursing would be a waste of time, that they would be destroying their career. Another one said, 'Well, of course, you need to do real nursing. If you want to do mental health nursing later that's fine.'

MR MORGAN: Yes.

PROF KING: So those sorts of comments weren't uncommon, and again, that's part of the reason why we went down the direction that we did, because of dealing with the stigma. So do you believe there's a stigma there and if you do, again, how should we be dealing with that stigma to stop it being a barrier for more mental health nurses?

MR MORGAN: Sure. I suspect there is stigma between medical specialties, so I think that that's what you're describing. Some undergraduates would like to work in mental health. They clearly do. In our network, there's little trouble filling the graduate program for mental health nurses, and obviously some nursing graduates don't, and they will vocalise that. I don't think it's any more complex than that.

The suggestion that an undergraduate mental health program will somehow provide a body of students - I'm not sure where that's coming from. You know, there's an expectation that, say, 18 to 21 year olds finishing VCE will line up to do undergraduate mental health nurse training. I don't see any evidence that supports that and I think it would be a much better way to increase the mental health nursing workforce would be to work on the existing undergraduates and improve that notion that mental health is an unhealthy place to work in. How do you do that? I don't know. Integration - the generalist nursing program has really only been around, certainly in Victoria, and someone might correct me from the floor, for about 10 to 15 years, so it's actually relatively early days, yes?

I am the last of the hospital trained, meaning institutional trained, nurses, and I'm 54. There's probably a couple that are 53, and we're the last of them. But behind us are a whole group of nurses that have postgraduate studies and some of them actually did an undergraduate mental health nurse program that existed for a period, and I think that it's clear that behind them as well are these new nurses that are completing postgraduate studies and given time that stigma will dissipate. I'm highly valued in my ED. I'm not looked down on. When I walk in, people are comfortable that I'm there and that's because they appreciate a nurse that can work in mental health.

PROF WHITEFORD: I have a question. So we've spoken to a number of employers, including in the private sector, who told us that they have just been unable to recruit Australian-trained mental health nurses. The only ones they - one employer told us it's been two years since they've got a new mental health nurse from within Australia. They've got them mainly from the UK, and they pay more, their working environment that I physically saw seemed to be attractive compared to acute public sector mental health and so the perception that there's mental health nurses with RN training who aren't recognised by a data set that we can use. Have they chosen not to work in mental health even though they're RNs

with mental health training, and if so, how can we get them back into mental health if they have that training but have moved out?

MR MORGAN: Are you refereeing my comment about how they're – - -

PROF WHITEFORD: Yes.

MR MORGAN: No, I think they're there. My comment really is that the report isn't accurate with respect to how many RNs are mental health trained.

PROF WHITEFORD: Sorry, so let me just clarify. I might have misunderstood what you said.

MR MORGAN: Sure.

PROF WHITEFORD: So were you saying that there were RNs with mental health training that are still working in mental health or - - -

MR MORGAN: Yes, I'm one of them.

PROF WHITEFORD: - - - these are RNs with mental health training who are no longer working in mental health; they're working in other areas of nursing?

MR MORGAN: No, I'm saying that your report massively underestimates the number of RNs with mental health nursing training that are working.

PROF WHITEFORD: In?

MR MORGAN: In mental health.

PROF WHITEFORD: In mental health. Okay. All right. So that even all those nurses who we haven't captured, you'd said in the report, the employers are telling us that despite that number, they are still struggling to get mental health nurses and have to import them from overseas. Is that your understanding in the areas you've worked or the colleagues you've spoken to?

MR MORGAN: Yes, there is, yes. Agreed, yes.

PROF WHITEFORD: And a suggestion for now to tackle that in the short- to medium-term?

MR MORGAN: Well, I think I've addressed that. Like, I don't think enough thought has been given to how we progress graduates of comprehensive nursing into mental health.

PROF WHITEFORD: And then by – - -

MR MORGAN: So, I mean, that's not my deal. I don't work in that area. You know, I don't recruit, yes? I think it would be valuable if the Commission spoke to directors of mental

health nursing and got their understanding of how they recruit.

MS ABRAMSON: If I might persist, Harvey - Professor Whiteford is actually reflecting the comments that he had to us, to be honest, that they can't get enough mental health nurses locally, that they're having to recruit internationally. We've also been given evidence during the course of the inquiry that those that - when students do come to them they then make a decision not to progress with mental health nursing.

MR MORGAN: Well, I don't think that's the experience necessarily in the network that I work at, yes?

MS ABRAMSON: I understand.

MR MORGAN: Yes.

PROF KING: Other questions? Comments?

PROF WHITEFORD: Not from me, no.

MS ABRAMSON: Thank you.

PROF KING: Thank you very much.

MR MORGAN: Okay.

PROF KING: Now, because you will be chairing after afternoon tea, when will I break until?

MS ABRAMSON: Well, we could do some (indistinct).

PROF KING: Yes.

MS ABRAMSON: We've got a phone call at 3.30, though, haven't we?

PROF KING: Yes. So do you want 3.40 or 3.45?

MS ABRAMSON: Well, we've got a phone call at 3.30.

PROF KING: Yes, it shouldn't take longer than 15 minutes.

PROF WHITEFORD: Are we breaking now?

PROF KING: Yes.

PROF WHITEFORD: We should tell everybody.

PROF KING: Okay. Ten to 4? We'll take a break for afternoon tea now. Because all three commissioners have a meeting that's popped up in our diary at 3.30, I suggest that we take

half an hour for afternoon tea. Apologies that that's a bit longer than we expected, but that will make sure that you don't all come back here and find no commissioners for 10 minutes. So let's reconvene at 10 to 4.

SHORT ADJOURNMENT

RESUMED

MS ABRAMSON: Well, thank you all for coming back after the break. I notice that we're actually extending the catering to the afternoon which I regard as a very good innovation if I could tell the staff that while we're here. So, look, thank you very much. I just wanted to reiterate a couple of issues. We do have a number of consumers who are going to speak directly and I just wanted to remind those people that we are live streaming the proceedings and we would ask that you are careful about not naming people or institutions, and whilst we don't ask you to take an oath of course we expect you to be truthful in your remarks, and for those members of the media we would be grateful if you could take account of the nature of the evidence that people are giving. So with that if I could just ask Mr Lawrence from First Step if you would announce your name and where you are from and I am sure you have an opening statement.

MR LAWRENCE: Yes, I do.

MS ABRAMSON: I feel like you're very remote over there.

MR LAWRENCE: I feel like I am very remote too, but this is the set up. Hi everyone, I'm the guy around the corner here. I do have an opening statement, but introductory to that my name is Patrick Lawrence, I'm the CEO of a not for profit organisation in St Kilda called First Step. And I shall launch into that opening statement, Commissioner?

MS ABRAMSON: If you would, thank you.

MR LAWRENCE: Which is written. I'm the CEO of Australia's pioneer hub for adults with complex and chronic committal illness. Across the Productivity Commission's draft report three words appear almost 500 times; I did the searching; integration, collaboration and team; nearly always to describe what should be, not what is.

At First Step we've been perfecting multi disciplinary outpatient care adults for 20 years, with no fees for clients, no referral required for most of our services and an attitude of unconditional positive regard. First Step also embodies non-judgment, trauma informed care, accessibility and the policy of no wrong door.

Reading through the Productivity Commission's powerful and comprehensive draft report it seems that the Commissioners were unable to unearth convincing examples of integrated outpatient care for adults with mental ill health. I am here today to point out that you missed one, if I can be so bold and cheeky. First Step are not for profit mental health addiction and

legal services hub in St Kilda. But it's not just a collection of independent services on one site, First Step is an integrated team of highly skilled, highly qualified clinical and non-clinical staff who collaborate constantly in the planning and provision of treatment to our clients.

This goes way beyond warm referrals at a single convenient location. This is detailed initial assessment and the formation of a purpose built multi disciplinary team for each client which can grow, change and reduce in size and scope, step up or step down, according to the client's ongoing needs.

It's important to understand the breadth of expertise and support we're talking about here all in one building. This is a long list. We have GPs with clinical nursing support; addiction medicine specialist physicians; psychiatry, psychology, both clinical and counselling psychology; mental health nurses, care coordinators, drug and alcohol therapists, peer workers, group therapists and family therapists. We also have psychosocial workers with access to brokerage funding; gastroenterology, Hep C, and a community legal centre. In fact it's the only criminal law practice within a health practice in the entire country with the possible exception of indigenous health.

What we aim for at First Step is incremental whole of life improvements. Any advances in recovery will be held back by the weakest link in the chain, for example harmful substance use, which is an incremental whole of life improvements are not a realistic goal without a multi disciplinary team working from a single site.

At First Step we see many people at the lowest point in their lives, and our ability to stabilise, support and empower them has led Professor Patrick McGorry to describe our approach as, and I quote, 'Exactly right to tackle the tenacious co-existence of mental health and drug and alcohol problems and it's having great results.'

We treat two and a half thousand people every year, support more people on opiate substitution therapy than any other clinic in Victoria, and we've developed a peerless reputation among service users and indeed other services in the south east of Melbourne. In conversation with clients I am forever being told, 'This place saved my life.'

The critical element of First Step is our multi disciplinary model, and its obvious benefits are the immediacy of secondary consultation and ongoing collaboration. But this approach has structural, attitudinal and indeed ethical elements that create a unique eco system with countless benefits to clients, practitioners and the community. I will list just a couple of them.

We have a much greater capacity to manage risky or highly at risk clients including serious violent offenders through the team approach. We can ensure continuity of care as patients are stepped up and stepped down within the same organisation, not being referred to somewhere three suburbs away in two months' time. We minimise the risk of people falling through the cracks, a phenomenon that we're all familiar with, and we have daily inter disciplinary conversations that expand clinical knowledge. You can imagine that you're going to learn more from working with a psychologist if you're a GP than if you're going to learn from

working with another GP for instance, and if you have mental health nurses and psychosocial workers we learn a lot.

In closing: cost. The Productivity Commission estimates \$1,200 plus for an acute bed for 24 hours; non-acute almost \$600. The Council of Australian Governments provides figures of \$300 to \$400 per day for incarceration in Victoria. At First Step with intensive support multiple consultations every week from a team including a GP, mental health nurse, care coordinator and psychosocial worker, ongoing legal support and two monthly appointments with a psychiatrist, the cost of all those services together over the course of a year would be just \$29 a day.

That includes organisational overheads so that the place doesn't fall into a hole in the ground, and the calculations and funding sources are detailed in this handout that I will give you in a moment, but I will wait a moment or else you will just be absorbed by that I'm sure. Twenty-nine dollars a day; comprehensive multi disciplinary team care in the community of a kind unique and intensity to First Step. For one-tenth of the cost of incarceration or 6 per cent of the cost of a non-acute hospital bed. And it's about getting better.

The goal all the while is to stabilise, support and empower our clients. For most people reliance on services will reduce over time, which is the exact opposite of what typically happens when someone is released from prison or discharged from hospital, often without adequate supports and often in practice into homelessness.

In an urban setting the First Step model is absolutely scalable and replicable by other organisations across the country. First Step looks and feels like a friendly GP clinic and is mostly funded through Medicare and through the primary health network, in our case the south eastern primary health network. Both of these systems obviously apply all across Australia. The Productivity Commission's draft report identifies an upper limit of approximately 250,000 Australians needing intermittent care with, quote, 'Episodic or persistent severe mental health and complex needs.'

To support the most vulnerable 10 per cent of that group in the manner, the intensive manner that I've described above would cost 300 million per year approximately based on my calculations. That's for 10 per cent of the most at risk a quarter of a million.

The health economists can calculate - I'm sure there's plenty of them here - health economists can calculate how much of the annual burden of 180 billion identified by the report would be saved by this intervention, in terms of reduced hospitalisations, reduced imprisonment, reduced welfare payments, decrease deaths including suicide, and increasing wellbeing social connection and participation, but it would be expenditure in the millions for savings in the billions.

The Productivity Commission needs to closely examine First Step, I would say, and consider our successful model in its recommendations with regards to, (1) closing critical gaps in healthcare services, which we all know is reform area 2, and fundamental reform to care coordination governance and funding arrangements, reform area 5. I extend a warm welcome to the Commissioners, to their staff and to anyone here in the room to visit First Step any time. Thank you.

MS ABRAMSON: Thank you very much, Mr Lawrence. Did you have the document, you want that tabled as a formal submission?

MR LAWRENCE: Yes.

MS ABRAMSON: Thank you.

MR LAWRENCE: That's tabled out. So it's a generic document about First Step as well as the specific calculations - - -

MS ABRAMSON: Thank you. Can I ask you, like the model is really interesting, so two parts to it. The first part is how did you build a system, and the background to my question is when we've looked at difficulties with integration a lot of it has seemed to be around cultures and around the way that people work. So there's a health system culture, there's a culture within social work. So how did you get your model operational?

MR LAWRENCE: I think a key - well, the history of the organisation is that it started with a GP and we were doing rapid detox of opiates and they will check (indistinct) implants in the back room. I don't know if anyone here knows First Step, in the old days it was pretty fascinating back then. But I think the main answer to your question is that the teams are small and that familiarity with - the team is small. There's a total of 28 people who work for First Step and the full-time equivalence is 16, and the mental health nurses and the care coordinators and the GPs and the psychologists and the psychiatrists work together all day every day.

So their main modes of communication are actual case conferences that can be billed for the GP, which is a GP plus two other health workers. We have regular clinical meetings where patients who people are concerned about or want to discuss are discussed; of course that's every couple of days, and simply knocking on the door of one of your colleagues and saying have you got five minutes probably happens at First Step literally 30 times a day.

So they're working hand in glove and they come to appreciate each other's skills and expertise. It is so totally different from a written referral by a GP to a psychologist three suburbs away in two and a half months. It's the absolute opposite of that. You can imagine if people spend a lot of time together they learn from each other, and of course the staff have a particular interest in that multi disciplinary work as well. We attract people who like doing that kind of work, and I would also add this is not for people who have just finished their Cert IV or straight out of school, it's highly complex work and it does need skilled staff.

MS ABRAMSON: Do you have a view as to why - or maybe it has been used in other states and in other regions. It's the scalability issue.

MR LAWRENCE: Yes. Why is it not more common? I actually don't know. I mean I think the history of siloisation - I mean of course you've got physical health which is broadly speaking funded at a Federal level; mental health which is funded more frequently at a State level, although the PHNs make that all a little bit complicated. There's just silo after silo, and when we look at these bumper GP clinics it's kind of crazy that here's a wonderful big clinic

full of GPs. That's a culture that's developed. I don't know that that's good for billing and other things. How great would it be if every one of those clinics had two or three GPs plus plus plus all the services I've listed below.

Certainly in the area - working with severe and complex mental health, which we find is more frequently connected to addiction than not, and usually stems, and I have to add a caveat, this is not applied to any particular person and it certainly doesn't apply to anyone in this room, but this severe and complex enduring mental health where your life is at risk for 10, 20, 30 years is usually connected to significant childhood trauma, and I just don't think we've developed a system where we've thought, okay, let's really do an amazing job of looking after that group of people.

MS ABRAMSON: Do you think that the funding models have really worked against integration?

MR LAWRENCE: Yes, absolutely. It's very difficult - you know, we've got a small team. Of the 28 people there's three of us who don't work directly with clients, I'm one. So we're very service focused and to chase down all the necessary contracts we were very lucky that we formed a strong partnership with SEMPHN, the South East Melbourne PHN, without which we certainly couldn't be doing this work. I think that it's fair to say I would want a lot of services to replicate First Step, but not without some additional government support.

We are not really financially sustainable. We manage, we sort of scrape through from year to year with a lot of help from philanthropy, but when we're talking about overall expenditure the Federal Government's proposal for eight new pilot adult mental health hubs across Australia they're talking about \$16m per year per hub, we need about 200,000, 300,000 to stay financially sustainable, and the best thing about those two funding sources they talk about, the PHN, that's in place, it's there, and Medicare - well, you don't even need to apply. I mean it's a guaranteed source of funding for GPs in that context.

MS ABRAMSON: Of course it pays for some of your services - - -

MR LAWRENCE: Of course it does.

MS ABRAMSON: - - - but not all of them.

MR LAWRENCE: Yes.

PROF WHITEFORD: You said funding comes from the South East Melbourne PHN, philanthropy and billings to the MBS through the health providers who work within - - -

MR LAWRENCE: That's correct. Like normal GPs they pay a percentage of the billings as rent at First Step.

PROF WHITEFORD: The State Government?

MR LAWRENCE: Very little at the moment. We've had some support with building upkeep and we - First Step Legal that are hardly talked about but is really quite an amazing

part of what we do is significantly funded by the Department of Justice and Regulation at the moment.

PROF WHITEFORD: The second question relates to I guess the cohort. Are they clients or consumers that you have the service for an extended period of time, like years here?

MR LAWRENCE: Yes, they are.

PROF WHITEFORD: And if so is there - if there's no flow through of clients is your intake therefore limited by your capacity to manage the clients current on your books?

MR LAWRENCE: It certainly is, and I need to clarify that in the last financial year we saw just over two and a half thousand people. A lot of those people are connecting with us to support them through opiate substitution therapies. So we're seeing them at a varying basis, but sometimes once a month or once every two months. Methadone and Suboxone, there is more evidence linking them with reduced negative outcomes than any other drug treatment available at the moment, and we certainly believe that they are appropriate for a lot of clients.

One of the benefits of that it's sometimes described as chemical handcuffs, and I can fully appreciate that, but sometimes we will have clients that will stay connected with us through that process and then things go wrong in their life, a partnership ends or a parent dies or children are taken away, and that's a very common part of our work, and we still have that client engaged, partly through the opiate substitution therapy. That's one source of having people engaged for a long period of time. But really when we have someone who has a very complicated childhood history of abuse and neglect we expect to be working with them for a couple of years at least, and certainly we have some people who we anticipate supporting for the rest of their life as long as they need our care.

PROF WHITEFORD: And the last question, sorry - and so what does that do to your intake, like what - - -

MR LAWRENCE: Yes, sorry. Well, at the moment - so technically you walk in the front door at First Step and ask to see a doctor, and you would. At the moment we can't take walk-ins, we're effectively closed because we are at capacity and we can't get you in front of a doctor for six weeks, which is quite a recent turn of events, it's been the case for about a year. We still take the most complex clients no matter what our capacity, because we know that there's no one else really in the outpatients sense who can work with them, but the PHN funded programs are - we have what's called mental health integrated complex care which is the complex end of stepped care, so below the public mental health system and hospitalisation. There's mental health integrated complex care.

That steps down to access to psychological interventions - sorry it's so jargonistic - but clients are stepped up and stepped down through that program and ending their contact with First Step when things are going badly or a lot better. But also any drug and alcohol mental health organisation will have people that just stop coming. We certainly have that. Loss to follow up is not an uncommon outcome, and sometimes we think, well we've done two years of great work with this person, we don't know where they are now, but we know that at least

they were well for those two years, so sometimes that creates capacity within the organisation. It's not something we celebrate, but it is an aspect of work in this area.

MS ABRAMSON: Could I ask about First Step Legal. We've got a lot of emphasis in our report on diversion, and I'm just really interested that kind of your model is the legal side of it and whether that's mainly an interaction with the criminal law you talked about having a cohort with drug addiction, or whether it's the civil issues as well.

MR LAWRENCE: No, it really is criminal law and family violence law. So our team works almost solely in that area, although we do a lot of work in the space of fines through something called work and development permits, which I can never remember because it has the worse name ever, which means attending the clinic to pay off infringement fines. So that's something we do clinic wide. In fact we've paid off about half a million dollars' worth of fines in that manner. By paid off I mean they were waived when we provide evidence that they have been attending this session and that session, but the work of First Step Legal they have an unashamed goal of keeping people in the community and linked to their families rather than being incarcerated for crimes related to their addiction. They can be directly drug related crimes. There can also be crimes of theft and there can be crimes of violence during that period in people's lives as well, but that's very much the focus. We were the first health justice partnership really in Australia, and partnership isn't really quite the right word, First Step Legal is just part of First Step. It's not a partnership, it's part of First Step, like the GPs or anyone else.

MS ABRAMSON: Could I also ask whether you've had any evaluations done of your program or whether you intend to have any?

MR LAWRENCE: Fabulous question, Ms Abramson. It is - we've been working up to that. So we've had - we've done some theory of change work that I'd be happy to provide to you, in fact it's in this document, with Social Ventures Australia. We now have two ongoing research partnerships with the University of Melbourne, School of Population and Global Health. One is a global literature review of clinics as similar as to ours as we can find. That literature review is underway at the moment, and we have just recently - we're applying to the Ian Potter Foundation and we have applied to Freemasons. We'll apply to Vic Health to do a longitudinal study with our own clients through surveys and linked data, so looking at things like hospital admissions and incarceration during a period of time before people attend the clinic and then during their time at the clinic. Probably not after, I don't think we've got that much money, but we're working very hard on that at the moment, and Professor Jesse Young has particular expertise in this area and is sort of our man on the inside at University of Melbourne.

MS ABRAMSON: Good. It's very interesting and thank you for making the time to come to talk to us today. Harvey, did you have - - -

PROF WHITEFORD: Thank you very much.

MS ABRAMSON: Thanks very much.

MR LAWRENCE: It's very much my pleasure and I extend again that invitation to Commissioners or staff - - -

MS ABRAMSON: That's a very interesting invitation.

MR LAWRENCE: Come on down.

MS ABRAMSON: Thank you. Thanks very much. Could I please call the Health and Community Services Union, and if you would be kind enough when you take your seat to announce your names and where you are from.

MR HEALEY: My name is Paul Healey, I'm the state secretary of the Health and Community Services Union. We're the union that covers mental health and disability in Victoria. We've been around since 1911 and been very much focused on working in the mental health area with staffing and also been very active in advocating for better services. I worked in mental health myself for 26 years. I started at Brierly in Warrnambool and worked at Larundel and Bundoora Repat and then I finished my career working at the Royal Children's Hospital Adolescent Psychiatry which I found to be an exciting job and lots of fun, and used to be embarrassed sometimes to get paid because it was so much - so enjoyable working with the young people.

We have looked at the Productivity Commission's report and we've just picked out five or six things we'd like to speak to if you don't mind, and the first thing is about the recommendation 7.1 about determining (indistinct) paying for beds and acute services for subacute (indistinct).

We believe there needs to be a really strong integrated approach so that the right bed, the right service is there at the right time for the consumer. I'm a great believer in choice in that the consumer should have a choice for where they need to go at the time of their recovery. I also believe that it should be very much in preventative model so people get in early and have the right opportunity.

I heard earlier today about vacancy rates and I think, you know, lower rates, having beds available at all time is a really important thing for people to be able to step up and choose. We had a model when we worked at adolescence where young people had vouchers where they could ring up and within 24 hours we'd admit them, and that stopped all those crisis, people self harming or getting the police and ambulance involved, they'd bring themselves to the unit and that was a fantastic way that we made sure we had opportunities for people (indistinct) and they need to be there.

In Victoria at one stage we'd have 3,200 beds and currently we've got about 1,400 beds and with the population doubled it doesn't meet the needs. We also believe that diversity of bed stock should be expanded in subacute forensic AOD and step up step down, even (indistinct) split CAMHS with the growth in young people, and also to review to actually meeting the needs of the future population.

We are a great believer in building hubs that are connected. We look at both bed-based and community-based hubs where people come and have all the needs met and all the things. For the community-based hubs we really think it is about building community, not just about

service, that you have places to go and that all the things you require for your treatment, AOD services, legal services. We also believe there should be art galleries and libraries and cafes and social ventures there so that people can go there and build community. Also indigenous safe spaces and actual community spaces. We think that's a model, and it's been seen overseas, that would work well in Victoria, particularly in the outer suburbs and also in the regional area, and we've picked out a spot in Bendigo, a nice spot to build our first hub if we can ever get one built, so we think it would be fantastic. That's one.

Recommendation 8 about alternatives to emergency departments for people. We absolutely agree. We think that the general public emergency departments are no place for someone to have (indistinct) illness. We actually very strongly support re-establishing the CAT teams and outreach teams so people can be treated in their homes, that people can get the services they require. I met a gentleman who walked up to me when I was on a picket line one day and he just said, 'I remember the old days, it was much better. I used to just ring up and they'd come and get me. Now I just stay sick, and if I want help I go to the library and play up and then they take me away', and he said it was not of assistance because he can't stand being in the ED department; it's too bright, too noisy and too distressing. So we think that outreach works, but also with the hubs, the hubs are designed that people know they could go to those places and reach out, and I think the Haven Café that St Vincent's runs is a great idea as well and you have a mixture of clinicians and peer workers and consumer care consultants there to help.

Very much about peer led services to welcome people and support people through their journey and to help them in urgent need. We are one of the first - I think we're the first union to have a proper peer worker EBA and to have the proper career structures path and wages and conditions, which we brought in eight years ago and we continue to develop. We're looking to develop that as sustainable careers, so we believe there's got to be four streams; one is research, one is education, one is practice and the other one is management. I always forget one out of four, but particularly the education, we think to build sustainable careers you need that educational support and that supportive supervision to actually aid people to develop their skills and maintain their careers.

In recommendation 11.3, direct entry training, that's where I started, I did direct entry training. I found it to be a really great way to start your career. At the time when I signed up I was unemployed or doing labouring work and I was able to get in as direct entry and start working, and you learnt your skills and then you did your training in blocks and went back and then consolidated what you learnt. So it was a really strong way to build your knowledge, but I don't think that one size fits all. I actually think the models we have as well, the postgraduate and grad works as well, and if I had my way - and I also believe that cadetship model as a third tier to it, that you bring people into mental health who have life experience.

For consumers they need people who have a diversity view and understanding and people who understand what they've done and where they've lived, and so when I started working I worked with all sorts of people who had various careers. My dad worked in mental health. He was a banker before he went into mental health. I've worked with shearers, plumbers, all sorts of people, and also it gave the opportunity for women coming back into the workforce after having kids and they were able to get into direct entry and was able to do it, and that

was really good. I know when I was a clinician I was very critical of parenting until I became a parent and realised how difficult it was and it changed me significantly in the way I work with families and understanding of what they are doing. So that understand, that life experience makes a huge difference to not only your practice but to the consumers you work with.

In Victoria we've currently got 450 vacancies in mental health nursing. There's 12 beds currently shut in Victoria because we can't get the staff. We're advocating for an extra 180 graduates a year, both nursing, allied health, so social work and OT, to actually develop a workforce in a much quicker way, and we've been lobbying for that over - for the next five years to get 720 staff, because no matter what happens out of the Royal Commission and other things that are occurring we won't be able to open services until we get the staff. Mental health is labour intensive, it takes time and takes people to sit down and work with people to understand them. It's that relationship you build with the consumer, but it's also the diversity of people that the consumer wants. So sometimes the nurse is not the right person for them, another peer worker, social worker, so it's about the diversity, a carer, that diversity makes a huge difference to the outcomes.

So we believe that the mixture of the three would be the way to actually develop the workforce, and I think that would give it longevity and a really strong workforce making sure you get plenty of people. Social work and OT currently in Victoria have no access once they graduate into mental health. There's no graduate programs, and we're advocating very strongly a two year of consolidation of practice, and that way to build them up, but generally speaking they had to go out and work in child protection or some other area and then they come back to mental health. So we think there's a role for a two year program for allied health as well to be built up, to build your workforce up.

Specialist registration: I never left - even though it changed with APRA I still wrote RPN on my notes when I changed my registration to an RN. I never changed, I was an RPN, I still refer to myself as an RPN. I think it's very important, and one of the most important parts is that actually if you have that specialist registration you can actually track and follow where the staff are, the nurses are, and what their registration is and how they work, so you can actually really work out quite clearly where the shortfalls are, and whose doing what.

I think that the more people that get mental health training the better it is. There's such a diversity of jobs and demand for mental health skills. You see - every new reform I get very excited, at the same time I get very scared because it's diluting the pool, and recently there's been 160-odd nursing clinical jobs put in schools and I think that is absolutely great, but it's 160 people coming out of mainstream, and plus because we're talking about the silos and things not working together, those people are employed under education, but they have no direct linkages with mental health services, and so they're left out on their own, and I think they should have supervision and support from the mental health services, also the ability to refer and work in a collective way.

I think any reforms that have people working in isolation is not going to work and it just puts a lot of pressure on the clinicians and it wears them out because they become responsible for all the difficult consumers in schools, so the kids in schools, and if you look at one in five in a school of 500 that's a hundred kids, so it's a lot of kids for one or two people to be looking

after. So I think they need all the support they can and the linkages, and the linkages are the most important thing where you get the experts. Clinicians are very good at identifying things wrong. They mightn't always know how to fix it, but if they can get to the experts to get them in and refer them through then you can actually make a big difference. So I touched on that one.

Recommendation 11.6 about negative perceptions, I personally - I guess the stigma comes through pretty much from TV and movies and how we're portrayed. Mental health nurses are portrayed to be big thugs in white jackets, and in actual fact it's 70 per cent women and there's not many big blokes, so it's not like that at all. I think while the system's in such a crisis phase as we're running at the moment there is a very negative thing. My niece has just started, she's a postgrad this year, so she's third generation in mental health in our family, and she absolutely loves it, and she's telling all her friends about all the great things.

The thing I used to love about it was when you had time to spend time with people, and, you know, I would spend sometimes six to eight hours with one adolescent playing games, and that's how I'd spend the whole shift, and it was fantastic. So you got to know the young person. You were working constantly about how to change what they're doing. You might teach them - I used to teach them to swear appropriately at the right place at the right time, which was a good thing because it stopped them getting kicked out of school, and things like that, getting to know the young person to understand how they are, and all day we'd have a dialogue going, not necessarily to look like it's therapy, but you'd have this dialogue going that you're talking about and shifting them what they think about things.

So I think if the systems change and it wasn't so crisis driven and that people had time to actually do the really core great work that we do and love it would lift the stigma significantly for staff to go and work in there because it's such a skills-base, and there's nothing better than, you know, you started a new hobby or something and bring it to work and start teaching people and run a group around that hobby, and we had music. I did adventure-based counselling at some stages when I had the knees for it, and climbing, rock climbing, and it was fantastic. So it's a really great job where you bring your great life experiences into the work and help people and you learn a lot. I think that's all I've got to say at this stage. Thank you.

MS ABRAMSON: Thank you, Mr Healey, we have got some questions. I did want to ask you though, I apologise if I didn't before, you've left a package of material with us. Do you want that treated as a formal submission, which is the best way for us to have things on the record?

MR HEALEY: Yes, please, yes.

MS ABRAMSON: Thank you.

MR HEALEY: Thank you.

PROF WHITEFORD: So one of the concerns that's been raised in the submissions that have come to the Commission relate to some of the community-based work, especially the mobile community-based work, and I met a whole lot of nurses, and the concerns about

occupational health & safety and the impact that's had on how many nurses can go out, one or two, and where they can go and what they can do, and whether there should be other first responders there, police or emergency services, paramedics, et cetera. Can you just comment on the impact that's had on the delivery of community-based care, especially mobile community-based care?

MR HEALEY: Yes. It's really been wound back over time. So when - I will use an example when I started training - we used to go to Portland which is an hour drive there, an hour drive back, and we'd go and visit a gentleman just to have a coffee. That was our job, once a month go and have a coffee, and that contact with that man meant everything to him and that kept him well, and that's all we needed, just needed to someone to actually acknowledge him being there, and we missed one month for some reason and he ended up in hospital a week later. So I'm a great believer in that you need those resources out there, but I think there's great benefits in having clinicians working with the police, riding out in a pacer. There's great benefit with the ambulance service which we're seeing as a trial in Geelong, but I also think there needs to be outreach, and you may need two clinicians, you may need a clinician and a peer worker, and I think we've got to look at the different groups of people and work in, not a one size fits all, but in a very smart way that suits the consumer, and by knowing the people who they are while actually working with them and knowing what suits their needs, and having that outreach is very important, and also it's about supporting the families. You can't underestimate the work that the families do and how they support their loved ones, and by us coming into their home and understanding their homes and how they work and giving them support at the time when you're there makes all that difference rather than queuing up at ED in crisis, and sometimes just acknowledging families what a great job they do is enough for them to keep chugging along and helping their loved ones.

PROF WHITEFORD: Sorry, one more question. Over time that you've been working in the area, especially as your union covers a number of different fresh groups working, have you seen a change in the mix of types of workers coming into mental health?

MR HEALEY: Not really, but what I have seen is the change of role. So they've made it very generic and I think that's poor. I think you need to have the specially skilled nursing, OT, so as to work those speciality skills. I think you sometimes do need generic case managers because it's easier to hire people, but I actually think those specialty areas, specialty skills, and we have now seen the emergence of the peer workers. We've had care and consumer consultants in Victoria for a long time, they're skills and knowledge makes a huge difference in the way they work. So having that whole team, and we've heard earlier about how the whole team works best, and when I started in CAMHS we had one of everything I used to say, and it was having those different eyes and ears and the different types of therapies available for people who had their own expertise and skillsets made a huge difference to the young people and their families because there was always something that resonated with them, and it's how that resonates with them. I used to say I was in the business of planting seeds and it's about putting ideas out there so people can grab the idea that suits them, rather than us trying to say this is the idea for you, and I think that diversity of skills and staffing is what makes a real difference to the consumer's outcomes.

PROF WHITEFORD: The last question before Julie jumps in. Is the information about the care worker EBA in here?

MR HEALEY: No, but I can send that through.

PROF WHITEFORD: Because I think one of the things that we've heard is how important the role is, but I guess how that's evolved, the differentiation, what that role is compared to other workers, et cetera, and you've had you said going for quite a while, so we would be very grateful to get - you know, develop what you have done.

MR HEALEY: We have a little bit of work to do on the four pillars, what we call the four pillars. We've just been working on that with VMIAC and Tandem and that, so we're just reluctant, but I will send it in as soon as we can.

PROF WHITEFORD: You have got until March next year.

MR HEALEY: Yes, no worries. So we should have it done by then because the EBA runs out next June, and I think it's really strong to have clear career paths and supports to make it a sustainable career for people, I think it's really important, and I look at - I won't refer to them all, everyone covered by EBA as workers, everyone's a worker, and you all come with your own eyes and skillsets, and I think that work in those skillsets in the EBA is really important.

MS ABRAMSON: I just wanted to ask a question about integration and given your experience, and you talked about a previous (indistinct). We did have people who had different skills, but they worked in an integrated way, and you will have observed, and thank you very much for making your comments against recommendations, that's been really helpful, but you've observed that we have been trying to think of systems to in a way force integration, so I'm just really interested in your views about some of the governance things we have been thinking about.

MR HEALEY: I think it all starts with the workers really, because they have opportunities to work across multiple sectors and multiple areas makes a huge difference, and when I worked - I used to be on intake at the Children's, and the big difference was if I knew the person at the other end of the phone I could work out what was going on and negotiate. So because we work in such silos we need to find ways, and I think one of the ways is getting workers work across multiple sectors, I think in Victoria currently there's a great demand for workers in family violence, drug and alcohol, the NDIS and mental health, and I think there should be a way that we get all those workers somehow working across, as they train, across those areas to learn and get skill up. I think as mentioned earlier the funding systems of two streams or more of funding is not useful. I find it's very difficult, but I think that the area potentially has its benefits, but I think I'm a bit of against the smaller - I think you've got to have a scale to actually make things run properly and for recruitment and to run the services. So there needs to be those linkages, but I think the relationships are everything, how you work with people.

MS ABRAMSON: Thank you. Anything?

PROF WHITEFORD: No, that's fine.

MS ABRAMSON: Thank you very much, Mr Healey.

PROF WHITEFORD: Thank you.

MS ABRAMSON: The next person I'd like to call is Mr David Clark. Mr Clark, if you'd be kind enough to state your name. I know that you're appearing I think as a user of mental health services.

MR CLARK: Yes.

MS ABRAMSON: Thank you.

MR CLARK: So my name is David Clark. Just for some background I'm currently on the management committee of Bipolar Life and I'll talk about that in a bit more detail in a minute, and I'm also organiser of Victoria's bipolar/mood disorder meet up group. We have about 400 plus members. And I've also recently become chair of a committee of governance for (indistinct) House, which has delayed me reading your report for which I apologise, because I've been sorting out governance for (indistinct) House, which has been an interesting journey.

Prior to becoming (indistinct) in 2011 I spent 20 years working in the UK National Audit Office and subsequently in Victoria in the Auditor-General's Office. In the UK I was involved in performance audit of the National Health Service, and then went on to the training team and headed up the training program for a number of years. That led to me becoming - coming over to Australia, engaging in a secondment at the Victorian Auditor-General's Office. During that time I was manager of an audit into patient safety which was published in 2004, so a bit of an understanding of the health service in Victoria.

I published my memoir in 2015 and I'm currently writing my second book and I'm looking at blogging and pod casting mental health in 2020. I also have got a few of additional comments if that's okay.

MS ABRAMSON: Yes, we would be very happy for you to take us through those. Thank you.

MR CLARK: Cool. Okay. So there is no mental health system in Victoria, and despite a plethora of Federal and State Government documents, including the Royal College of Psychiatry for Australia and New Zealand's guidelines into mood disorder management and various other publications, the current approach to supporting and grappling with a mental health is minimalistic consisting of diagnosis and medication primarily. The steps can (indistinct) progress, but again who decides at which level care or support is required for the individual grappling with their mental health. The system needs to be reformed through (indistinct) experience, not through psychiatry, although they have a valid advisory role.

There is a wide range of research (indistinct) diagnosis. I only found out what I was healing and recovering from this year, 2011, that's eight years after my diagnosis. My psychiatrist acknowledges the research in (indistinct) bipolar, which is my diagnosis, bipolar 1, is often associated with adverse childhood experiences of which I relate and accept is the likely cause

of my diagnosis, but it should not take me eight years to understand what I need to focus on healing.

Peer support is key and is so lacking throughout the funded health services in Australia. In 2012 I googled bipolar and Melbourne and found Melbourne - it was then called Melbourne Bipolar (indistinct words) Group of which I'm now organiser. I'm also on the management committee of Bipolar Life which facilitate (indistinct) experience support groups across Melbourne and is looking to expand into rural and regional Victoria to support those with a diagnosis. Again I found this organisation through Google.

Only through my tenacious resilience and persistence do I now have a fit for purpose counsellor through the local primary healthcare network, but I've had to persistently advocate for myself, no one has helped me. Since 2011 I have consistently attended appointments with psychiatrists. I have had no support from any other professional such as mental health nurses, mental health social workers, mental health case workers, mental health counselling until 2017. The only way I've been able to understand my diagnosis is through reading books, including personal memoirs on bipolar disorder. These books have been the foundation of my journey (indistinct) recovery.

Thankfully with the agreement of my psychiatrist I am no longer taking medication. This has been a personal choice. The side effects unexplained by my psychiatrist, along with no explanation as to why I was actually taking the medication were debilitating resulting in persistent head pains and daily physical exhaustion. I have been on Seroquel, Lithium, Escitalopram, sodium valproate and luckily Olanzapine. None worked for me. I'm now in a good place with my health and wellbeing, take cod liver oil tablets daily to support my brain's healing and it seems to be working. Again this has been achieved only through self-education and persistent determination to heal and recover from a six month psychotic episode in 2011 for which I was never sectioned despite seeing two different GPs, and a hypomanic episode in 2016.

Along with self-education training to be a life coach has helped me better understand and support myself. I'm now a trained Master Practitioner in (indistinct) linguistic programming and a master coach in (indistinct) link between head brain creativity, heart brain compassion and brain (indistinct), and that book using an (indistinct) brain to do core stuff saved my life. So that's my journey forward in terms of spreading the message. Again self-initiated and again delivering the outcomes required to address (indistinct) post diagnosis.

MS ABRAMSON: Thank you for sharing your story with us. What are the type of recommendations that you would be looking from us that would have made a difference to your experience?

MR CLARK: Well, as I've said information, explanation, planning. There's been nothing, absolutely nothing. My psychiatrist has said nothing about anything, so I don't know - I'm glad they've gone because I don't understand the point of psychiatry. I've had to do everything myself in a way. I will engage with (indistinct), I maintain seeing him every three months for half an hour, but there's been no help at all, so it's that bad, like where are all the (indistinct), and navigating a six month psychotic episode, having seen two different GPs that

were sectioned I have no legal underpinning of my health care, I have no anything underpinning my health care, it's just been self driven.

So that's why I'm slightly annoyed and slightly focused on making sure that others don't have to go through what I've had to go through and hence my connection with a meet up group, and again we hear the same questions, what medication are you on, what's your diagnosis, have you got a good psychiatrist, how do I find a good counsellor, how do I find a good psychologist, and they're just massively lacking, and also with the Bipolar Life providing support groups we are now looking - I'm going to a meeting on Thursday morning, we're looking at developing an online support, something like that to help people, because there's lots of information out there, it's just all over the place. So we're trying to bring it together to kind of guide people through self-education, self-empowerment so they can help themselves, because at the moment it's really not very much.

PROF WHITEFORD: So there's a lot of information out there, you type it into Google. Is what you're saying about what didn't exist for you at the time you needed it was, (1) access to that information, and (2) accessed information which was relevant to you to help you? So you could type it into a search engine, but what came back either wasn't relevant to you and it certainly wasn't what you needed from the clinicians with whom you'd had contact, the GP and the psychiatrist?

MR CLARK: To me where I am now it seems simple and easy, one to make sense of the symptoms. So my symptoms - so the (indistinct) I had is that I had warning signs that would last seconds. They appeared at the age of 19, at the age of 26, at the age of 34, at the age of 40-ish and they are the result of intense stress, work stress primarily, resulting in the collapse in the prefrontal cortex and then you just calm down and go - embarrassed what happened there. So having read people's memoirs they tell of similar symptoms, and when I'm reading these memoirs I'm going, 'Oh my God that's me', presenting at 43 went through again another work situation, extreme stress, my head just exploded and had this psychotic episode which I don't recommend for anyone. Healing that they just dosed me up with three different types of medication all at once.

I've never been into an inpatient ward, I've never had any outpatient support, it's just been have the medication, good luck, away you go, and the side effects were just debilitating and thankfully I'm off them all, and it's only through my own this isn't working and just kind of - even the last six months coming off medication I've gone through a whole bucket load of anxiety going 'Am I okay' every day, every second, 'Am I okay, am I okay', and I'm okay, but again there's been no support and there's no planning, there's no anything, so it's pretty grim.

PROF WHITEFORD: So you weren't connected with community organisation - - -

MR CLARK: There is no community organisations. In Stonnington - I live in Stonnington, there's nothing.

PROF WHITEFORD: Nothing where you are?

MR CLARK: Only recently I have got through the South East Melbourne Primary Healthcare Network a really good counsellor. She's absolutely brilliant, she's gold dust, but it's again my tenacious resilience to say I need someone through the psychiatrist to talk through what I'm experiencing, because I'm talking to you and you're not showing anything. So he didn't - he wasn't able to understand the side effects or anything I would say. It was almost like I was talking a different language, and so for half an hour every three months I would have an exhausting experience with an individual who's supposed to be trained in what I was experiencing and yet there was just nothing. He was definitely disappointing.

PROF WHITEFORD: The last question then. The counsellor you've got now you mentioned, that connected with that person through what - how did you find that person?

MR CLARK: So I did have, I don't even know what it was, some sort of counsellor through the mental health service hospital I was with, but again just total lack of understanding and it was just - some of her behaviour was (indistinct) as well, so it's by email. So I went back to the psychiatrist, he said, 'Well, we put you in touch with a counsellor and it didn't work - full stop.' And I'm, well, it didn't work because she made appointments to meet me and then failed to turn up, and then other times would say, 'I'm in a meeting, I can't meet you now.' Well, that's unprofessional and I just want to make progress and get on with my life. I don't want to deal with unprofessional people. So he was just like, 'Well, I don't know what else there is.' So he was just like, 'Well, there must be something', and it was only through me keep on badgering that he made this call to somebody else in a different part of the hospital and they found there was this South Eastern Melbourne Primary Healthcare (indistinct) counselling service which is only new, two years or so, but that's been brilliant, absolutely brilliant.

People with - people with a diagnosis are exhausted by themselves. They don't need to interact with a mental health system that makes them worse, and that's what the majority of the people I see have to live with. The system is counterintuitive, it actually makes people sicker, it doesn't make them better, and piling on medication after medication after medication, which I got through, is ridiculous, it's unethical.

MS ABRAMSON: Mr Clark, did you have anything else you wish to say?

MR CLARK: No.

MS ABRAMSON: Thank you so much for coming and thank you for sharing your story with us.

MR CLARK: Thank you, no problem, and we'll be putting in another submission.

MS ABRAMSON: Thank you very much.

PROF WHITEFORD: Thank you.

MR CLARK: Thank you.

MS ABRAMSON: And if I could ask Ms Reilly-Browne if she's present to take the stand, and if you would be kind enough to announce your name for the transcript and I understand you're appearing on your own behalf. Is that correct?

MS REILLY-BROWNE: Correct, yes.

MS ABRAMSON: Thank you.

MS REILLY-BROWNE: So hello, I'm Tess Reilly-Browne, and I really appreciate the opportunity to speak here. I am a counsellor in private practice in North Melbourne where I see clients face to face. However I have an inordinate number of clients that seek me via video link because I once had a practice in North Queensland, and old and new clients still seek me out from those rural areas.

I would describe myself as a trauma relationship therapist. I hold a masters of applied social science majoring in counselling, and an early childhood degree. I began my counselling career at Kids Helpline where even though I was still studying my masters they thought I was qualified to be holding that position. I then went into private practice. I've been accepted as an NDIS client - sorry, NDIS therapist. My qualifications were seen as adequate for that, and I've worked for numerous EAP companies, again seeing my qualifications as enough. I work as a voluntary counsellor for refugees.

I really enjoy working in multi disciplinary ways, so maybe working with a psychiatrist, a school teacher, counsellors, other psychologists or social workers and lawyers, whatever is needed to best support my clients. A lot of my clients are actually psychologists or clinical psychologists as they come seeking relationship help. I am a supervisor for other therapists and I have recently spoken at two conferences, the Australia Pacific Rim Conference that was hosted by the Australian Counselling Association, and the ninth Stop Indigenous Domestic Violence Conference.

From my clients and my colleagues I get really good feedback. They invariably say about the therapeutic alliance that I develop. Well, they don't exactly use those terms, but they will say, 'Tess really got me. She was warm, she was welcoming, it was easy to talk with her.' They will say things like, 'I have never heard my husband talk about feelings like that in 23 years of marriage.' But this isn't rocket science, because we have known since 1979 about Gordon's Theory of therapeutic alliance being pivotal in efficacious therapy outcomes, and that's what my degree was excellent in preparing me for.

Most times I know what I'm doing, but I definitely love what I'm doing. I know I'm highly valued and respected by my clients and colleagues. What saddens me is that the majority of Australia cannot access my skills or resources because they can't pay a full fee because I cannot provide the medical health plan, and on top of that the absolute injustice they have to pay GST as well when they pay my full fee.

I have lots of people who might seek me out through EAP or through Google review who cannot maintain that therapeutic alliance which they've developed with me. I am, sounding rather egotistical, a wasted resource in Australia, especially when we see mental health escalating for the younger and the older populations. I know I'm not the only one. I know

there are hundreds, if not thousands of therapists highly qualified using best practice guidelines and therapies. We would really love to be able to offer to a broader demographic. I would love if we could take off the GST and we could add people with qualifications like mine specifically in counselling to the Medicare rebate scheme.

I can give you an example without breaching client confidentiality of how this is so relevant. Shall I continue?

MS ABRAMSON: Absolutely. I was making a note because I wanted to ask you about the GST.

MS REILLY-BROWNE: So I'm going to be really careful. So I've had a woman from rural Australia contact me. Her husband had just been released from hospital after two months for severe depression and anxiety. Their relationship was understandably really struggling. I offered them a 90 minute session, which we did, knowing that that's probably as far as their financial resources could go at that time, but they were really desperate and they still wanted it. This is via Zoom. Yes, you can still make a really great therapeutic link via video link.

So they were lucky in that that they had the resources for that one 90 minute session, but then they have to pay the GST on top of that, and this man after that 90 minute session texted me saying, 'I learnt more from that session than I've learnt from most therapies or therapists', and I was thinking he's talking about the two months that he's just been in hospital. He wasn't. This man had suffered terrible trauma in his childhood. That's why he had these complex diagnoses now. He was talking about a lifetime of therapy.

Now, this isn't about who I am as a therapist, this is about there are lots of other counsellors out there who also are very good at developing that therapeutic alliance that is pivotal, and also working in a multi disciplinary team. So, yes, that man and his wife are left high and dry for the moment.

MS ABRAMSON: Can we ask a couple of questions, and I may have got this wrong so I'm apologising in advance. Private health insurance, do any of the private health insurers cover counsellors?

MS REILLY-BROWNE: Yes. That's the actual final kicker for this couple. They then contacted me going - we knew they had insurance, I have a provider number with their specific company, which is a very small group of people, and yet that company was arguing, the last I heard, was arguing not to give them this small rebate, even though they have full cover, even though I have a provider number. So not unlike David's story when they're in an incredibly vulnerable difficult circumstance not only are they not getting supported by the scheme we have at the moment, but they're getting incredibly frustrated and their life's been made more difficult.

MS ABRAMSON: Thank you. One additional thing if I may, Harvey. I just want to ask you about the GST and my (indistinct words) get this wrong. I'm assuming that GST is payable because it's not a medical service, because I presume there's an exemption for medical services. That would seem - - -

MS REILLY-BROWNE: So, yes, but a psychologist wouldn't have to - but I would say I am practicing the same therapies the same way - - -

MS ABRAMSON: No, I understand the point.

MS REILLY-BROWNE: So, yes.

MS ABRAMSON: No, I understand.

MS REILLY-BROWNE: It's really inequitable.

MS ABRAMSON: I understand. Harvey?

PROF WHITEFORD: So we heard this morning from the Australian Counselling Association that there are about 5,000 members of the Association. This may be a question you don't have an answer to, but one issue in looking at remuneration for counselling would be to know within that 5,000 members who, with all due respect like you, and who might not be. So the quality control of that group and the consistency with which they would deliver evidence-based and effective counselling services.

MS REILLY-BROWNE: Okay. I can address that to a degree in that we must - to stay affiliated to the body, and I belong to the Australian Counselling Association, but I have belonged to PACFA as well - that we must have professional development every year, and we must have ongoing supervision, which not all other similar bodies do demand here. So I think in that way we've got some level of requirement, and supervisors have to be affiliated, so I have to have done training to be a supervisor.

So I would say it's as ethical as any body. That would be my experience, just having been at that conference where at least 500 people attended, the ACA conference. There's a high level of skill, but I think what really sets them apart is the ability to be with their client, to see the person, not the diagnosis, and invariably it will be me sharing with perhaps like David says a psychiatrist that hasn't had an hour and a half sitting with a client, or the lawyer who isn't trauma informed when there's a child welfare case.

PROF WHITEFORD: Thank you very much.

MS ABRAMSON: Thank you so much.

MS REILLY-BROWNE: Thank you.

MS ABRAMSON: And I understand, I'm looking at the staff at the back, that we do have somebody additional that wanted to make an appearance. Is that correct? Thank you, if you'd be kind enough to say who you are.

MS HANSEN-VELLA: Thank you for the opportunity to speak today without being on the listing previously. My name is Donna Hansen-Vella and I'm a mental health nurse of almost 30 years now. I have a background of working in clinical mental health services, both public and private. I also have 12 years working with the Australian Nursing Midwifery Federation

in this state, which I resigned from earlier this year. That role was predominantly within mental health services and been part of a negotiating team for the enterprise agreement, but also around implementing workforce innovations. At times I was also used by the Federation to be their representative on the national forums.

I'm not here today representing the views of the AMF, but just put that forward as part of sort of the context to my background. I also am a member of the Australian College of Mental Health Nurses who I understand have been specifically mentioned in some of the recommendations that are in the report.

I have sought to speak today in the context of some of the information that's been put forward today in the context of the workforce recommendation around 11.3, more specialist mental health nurses, and seek to actually contribute to that conversation. There are other elements of the report that I would seek to put forward and I will actually give a written submission as well, and thank you for the opportunity to be able to actually do that. That's an amazing opportunity that we have.

I also think it's important to put forward that I am the daughter of a mother with mental illness. So pretty much for most of my life have had that, and a stepmother too, a young woman with fairly severe mental illness.

So in terms of draft recommendation 11.3 I am a little bit concerned by the second dot point being in the medium term. I think it's too long. So I think that the work that the Productivity Commission has done has been very thorough in talking with a large range of stakeholders and actually getting to the nuts of our issue for my profession of mental health nursing, and that is that we are actually - a lot of people have used the terminology that the system is in crisis - as a profession we are actually in crisis.

There are a range of matters, and I think this is why I felt I wanted to talk today, because you had asked one of my colleagues some questions about why was it that you were hearing from some employers that they were having difficulty with recruitment, and yet we know that we have more nurses than we can actually take into graduate positions in the mental health sector, we knock them back.

So what I wanted to share with you is that my experience of that particular issue over the last 15 years, because I've had the opportunity to speak directly with most executive directors of nursing, health service organisations, State Government, around this - and members on the ground around this particular issue, or nurses on the ground, is that what the employers inevitably want from day one are mental health nurse to walk through their doors and be employed. That's not an option here in Australia. It hasn't been an option since the mid 90s. So I was probably one of the last people to go through the university-based training as a direct entry psychiatric nurse. I wanted to do it in hospitals, but it closed the year prior to me finishing HSC, so I had to do it through the university system. Now, that actually closed down that way of training in the mid 90s. So we then moved to comprehensive nursing.

That comprehensive nursing when it was under the state and territory regulation actually had some rules about what were the minimum requirements that needed to be provided in relation to mental health content. When we moved from the state and territory system to national

registration or regulation of our profession, as did the other health practitioners in 2010 I think it might have been, they did not uphold what we had in some of the states and Victoria was one of those, a requirement to have minimum requirements of mental health content in the curriculum.

So in actual fact what we have now is a comprehensive bachelor of nursing course that depending on what university you actually go to will actually influence what sort of mental health contents, and even what placement you get, and, you know, we have in Victoria some - and I'm mindful of not naming in today - but we have some really good university providers that have very passionate mental health nurses on their teaching curriculum and have managed against all odds - because there is stigma, there is still stigma about, you know, don't go into mental health, or do general before you actually decide to go into mental health.

I can even recall my own stigma when I was doing - because I did my general nursing after my mental health nursing and when I was a student of general nursing being told that once people discovered I was a psychiatric nurse, 'You only deal with the kind of - from the neck up stuff, you don't get your hands dirty.' Like that sort of stigma was real, and I have a niece who is currently - or two nieces actually doing their undergraduate training, both of whom tell me about similar stories on their placements, and also from within their teaching schools as well. So it is real that that actually happens, and I think it's not surprising because I think university and teaching situations are communities like we live in communities, and there is still stigma or fear in those communities.

But getting back to what happened we then lost our direct entry psychiatric nursing training. We then started moving towards comprehensive nursing training and it's now a bit of a choice by the universities as to how much content you have and how many placements somebody might have. We even have students that for their psychiatric placement get counted going to a nursing home as their psychiatric placement. Now, clearly there are residents in the nursing homes that actually have significant mental health needs, but I wouldn't - as a mental health nurse I wouldn't classify the nursing home as a psychiatric placement for an undergraduate student. So it is this incredible amount of diversity about not just their academic preparation but their placements.

As I said there are universities who are doing a really, really good job and they're the students that in my current position as a senior psychiatric nurse that I want to employ, because I know that they've had the right amount of, or at least a better amount of undergraduate academic preparation and also clinical placements. They aren't though from day one on the whole in the sector considered a mental health nurse.

Now, what they need to do to become a mental health nurse, and we are very, very strong on this in Victoria both professionally and industrially is jump a few more hurdles. So, you know, they've come out of their three year comprehensive training, they have their university debt, and they come into employment on day one. Inevitably they're not given a permanent position. We have two area mental health services that will now give them - because they've had to address the gap in vacancies, but everyone else is still putting them on a fixed term position.

So when you've got an option to walk into another specialisation in the hospital in a permanent position from day one versus you're still passionate about mental health, but you need to come in and enter into a fixed term contract for two years, both on 12 months, so you have to be interviewed, get that job, you're given a 12 month fixed term position to be a graduate nurse in mental health. You then have to reapply, be re-interviewed and hope that you're successful in getting the next 12 months position in your postgraduate. It's a funnel.

So the amount of graduate nurses that we can take into mental health is around 190 at the moment in our state, but the amount of postgraduate nurses that we can take is less. I understand it's around 110, it depends which data you read. So, you know, we already are narrowing our intake of our new workforce. Once again as I said they're not considered a mental health nurse. So the first two years commitment to practicing with your mental health and coming with, you know, in secure employment they're still not considered a mental health nurse amongst everybody that they're actually working with. We don't apply that bar to our allied health colleagues. Our allied health colleagues as my colleague from the Health and Community Services Union mentioned can when they've done a little bit of time somewhere else, child protection, can apply and be appointed to a position within say the community mental health team, and they're not questioned about their experience and they're given a permanent position. But we don't have that option for nurses within this state.

My other colleague Andrew Morgan talked about the potential for an internship. We've actually had that option available industrially for the last seven years in this state. Our employers are not using it, and they're not using it because of their concerns or I guess part of the culture that that person still isn't a mental health nurse. So we actually have some very major employers going over to the UK depleting their system, that's my personal view, of their mental health nurses and bringing them back here and then having to do enormous effort at helping them to acclimatise to not only working within the Australian mental health system, but also just acclimatising to living in our community.

So inevitably I'm making a plea if recommendation 11.3 could be considered to be shortened. In terms of the steps that you've outlined there it's already known, it's known what the curriculum is. My colleague Michael Blair earlier this morning mentioned Professor Brenda Happell who is well known regarded academically, received significant awards for her leadership with relation to academic and inclusion of consumer workforce within co-teaching of the curricular, has already got the curriculum. I suggest that she probably needs to update the curriculum in comparison with Charles Sturt University's course that they deliver for indigenous mental healthcare workforce. Fabulous, I wish that we actually had that available for nurses. Even though it's delivered through their nursing and midwifery department it's not available for nurses as such in terms of it being a nursing course. So, you know, that sort of stuff can happen very quickly, it doesn't take up to two years.

You've suggested in the medium term specialist registration. Well, that was already discussed and debated back in 2010, and in fact there was recognition that the law for regulating health practitioners already actually enables for recognition of specialisation. It's how doctors are able to do it, it's how psychologists are able to do it. It's even how some forms of dentals can actually do it. It's there and it's available, it shouldn't take two to five years. I think that that's waiting too long.

The second thing that I wanted to talk to was just around - a lot of the recommendations, which I really welcome around the step model, probably haven't picked up on the issue for my profession as a mental health nurse, and that issue is that the kind of stuff from around really step 3, around that sort of access to focus psychological therapy, mental health nurses are now excluded from being providers of that. So we used to be eligible to be providers of that under what was known as MHNIP, so mental health nursing incentive program funding. It was the Commonwealth funding. (Indistinct) that actually enabled an eligible organisation. Inevitably it was meant to be the doctor or the psychiatrist that could actually employ mental health nurses.

Now, this program, Commonwealth funded program, has been evaluated on at least two occasions. One of those was actually funded by the Commonwealth when they actually were needing to evaluate it, and provided the actual - which goes to the heart of the Productivity Commission - provided the evidence about not only its effectiveness in terms of client outcomes and outcomes for families, but also the cost effectiveness of that program, and unfortunately that program was frozen by the Commonwealth and then has actually been absorbed into the primary healthcare networks. So there's actually no requirement - firstly, it doesn't exist anymore, there's not a mental health nurse incentive program any more. So our communities do not have access to mental health nurses in the community unless they're actually managing to get to see, which you've heard a lot about the hurdles they need to jump through to get to see someone who's employed in a public health service or someone working within private practice, and those people who try to set up their own private practice who are nurses, mental health nurses, inevitably struggle because they don't have access to the MBS item. So I just encourage you to consider whether you would extend those recommendations to have something specific to the disciplines who do not actually have access to MBS items, because inevitably they're sound recommendations, but they exclude mental health nurses by the fact that they are not eligible for MBS, to be an MBS provider of those items.

MS ABRAMSON: I understand that. Harvey?

PROF WHITEFORD: No, you've said it all.

MS ABRAMSON: Every time I thought we were going to ask a question you answered it.

MS HANSEN-VELLA: And I just - just the very final thing, and, sorry, I am very mindful of the time and thank you for allowing me to speak without prior notice, is around that, the earlier conversation about the sort of proportion of direct care that somebody might actually be able to provide somebody. So within Victoria in the industrial instrument there's actually regulation of that, and the regulation is what we call a 60/40 system. So all of our community mental health clinicians employed in the public sector have a community workload management system. I think it's actually Dr King was in his earlier career employed by the state to actually evaluate what was in the old psychiatric employment agreement and never implemented. Even though it was an EBA requirement only two out of the health services did it, and he did a lot of research in looking at models at that point in time.

We then took his work, so I just want to recognise in his absence the amazing work he did in that space, took his work a step further to actually require regulation of that, and how that was done was by mapping the work that was happening in public community mental health

services. Now, in public community health services there's this layer of administrative stuff which is kind of covering risk that goes on. So once we mapped all of that it actually turned out that 40 per cent of the community clinicians time needed to be quarantined for what's industrially described as organisational duties and functions, and the other 60 per cent of their working time is available for direct care. That direct care does also include secondary consultation, all those sort of duties. So that's probably one of the I guess most advanced pieces of work that I'm aware of in our country that's actually done that mapping out.

PROF WHITEFORD: Have you got - do you know where we get - - -

MS HANSEN-VELLA: I'm happy to provide that to - - -

PROF WHITEFORD: That would be great, thank you.

MS HANSEN-VELLA: - - - to the Commission. So it's public in terms of the enterprise agreement.

PROF WHITEFORD: That would be great, thanks.

MS HANSEN-VELLA: But otherwise, yes, unless you've got any questions about that work.

MS ABRAMSON: No, no, it's been fantastic, and in your written submission which you've been kind enough to say you will do really interested in that diagrammatic thing you talked about the funnelling of graduates, and actually it's that practical type stuff we're really interested in, but thank you for appearing today.

MS HANSEN-VELLA: And thank you, thank you for the opportunity.

PROF WHITEFORD: Thanks, Donna.

MS ABRAMSON: And we have one other person. Thank you. If you'd be kind enough to announce your name for the record and the capacity in which you appear.

MS MULLEN: Thank you. Thank you very much. My name is Barb Mullen, I'm the founding chairperson of BPD Community; that's Borderline Personality Disorder Community, and I would like to thank you for your report and make a strong point how we value the work that you have done.

BPD Community has existed since 2015. It's a grassroots peer led organisation. It's an independent organisation, it's a charity for right. Personally I myself am a carer. We are a charity for people with BPD, their families and friends and those who work with us, particularly those who work in the community sector of which there are not that many more here in Victoria. We have no funding, we have no staff, we have no infrastructure, yet we've offered services and programs that do make a difference and we are told how much they make a difference and we've done that since 2015.

I want to make a couple of points because I'm unsure as to what particularly address and so I want to leave it open if you do have any questions, otherwise it's very short and simple. I want to make a point about stigma and discrimination. In relation to BPD from the work that we have done and the studies that we have done and the research that we have done, or the research that we have read the stigma and discrimination emanates from within our mental health system and our mental health professions in spite of the best intentions of all of the good people who work in there.

I would like to make the point that anecdotally less than 2 per cent of people in Victoria are treated in a year; 2 per cent of people with BPD are treated within a year. That's based on an anecdotal estimate given to me, about 4,000 people a year being treated, and that's based on the American accepted prevalence figure of 5.9 per cent equating to approximately 350 people here in Victoria who would need a diagnosis of BPD.

The sad thing is that recovery from BPD is a realistic possibility. Recovery has got three components we believe; treatment, social and relational supports. I'll talk a bit more about that in a second, but I want to make the point that we know that when we're in a privileged position that we fail to see the privilege that we're in, and I want to make the point that the medical model is privileged within the mental health system, and therein lies a big dilemma for us, and I humbly suggest that when the medical model of treatment supports is privileged then social and relational supports are seen as an adjunct, as an extra, whereas the clinician and the treatment is seen as the central thing.

We see those three components as equal partners, and that treatments, social and relational supports together can lead towards recovery, and that perhaps treatment is not necessarily essential, but social and relational supports are. Currently in Victoria the medical model is privileged, and the interim report sadly doesn't inspire confidence in me that this will change.

I wanted to make the point about relational supports to explain that just a little bit further. With BPD we take the simple - with BPD Community I'm sorry - we take the simple explanation of BPD as having five areas or five domains of dysregulation; emotional dysregulation, behavioural dysregulation, relational dysregulation, cognitive dysregulation and identity dysregulation, and we choose that simple approach in order to understand the enormous complexity that BPD can present.

Relational dysregulation is a really important aspect, because it places families in extraordinary trauma, and we know that people with BPD may have - there are all sorts of ways of explaining it, to explain the relational dysregulation, and one common theory is attachment theory, but relational dysregulation is really traumatic for the person with BPD. But the effect on that within the family is extremely severe, and yet it is families who are the ones that are often carrying the burden of support for their loved ones. So I want to make that very, very strong point about relational dysregulation or relational support, as well as support for employment; legal support as mentioned earlier with the example from St Kilda, and budgeting support, other sorts of things like art therapies, even something as simple as singing, a whole complex way that you can engage people in community to help them ultimately achieve their potential aside from the demands of treatment and the clinical environment.

I would like to leave that there, because that's short and simple, and then if you have questions please I'd be very happy to answer them.

MS ABRAMSON: No, that's been very helpful. Harvey?

PROF WHITEFORD: So just one question quickly. With the support network when you say what's lacking is I guess the social and relation component, or when funding is tight or time is tight they seem to drop off first if they were there to start with. Is that because the clinicians the members of the community have seen don't recognise it, or that isn't available for the consumers to access?

MS MULLEN: I think it's both those things and I think it's also more complex. I made the point about 2 per cent of people with BPD get treatment, and so the people that we see in our community many of them don't get treatment at all. Many people don't get a diagnosis.

PROF WHITEFORD: They don't get clinical treatment even?

MS MULLEN: Don't get clinical treatment. Two per cent approximately get treatment. They don't get diagnoses, and as was made, the point was made earlier that with a diagnosis then you've got access to Google. You know, you can find things out, you can find out and you can learn the techniques, because the sad thing is BPD is a condition for which complete recovery is possible, and there are techniques that families and friends can learn that can support their loved ones as well as themselves, and all of that is within range except 2 per cent approximately a year get treatment. Of those some of them don't even get diagnoses. Then there is some, well over 90 per cent of people who have a need for things, for supports, but they're not getting them. So if you look at in a clinical environment it's the medical model that dominates, and so when I make that point about privilege when the medical dominates that's what they see. They don't see those supports as being important.

PROF WHITEFORD: Critical. No, I understand. Thank you for clarifying.

MS ABRAMSON: I have two questions. The 2 per cent that you've been talking to us about where is that based on, is it a survey or - - -

MS MULLEN: It was anecdotal. So I asked an eminent leading psychiatrist in the BPD Community and the BPD world here in Victoria and his estimate was based on his own organisation and what he knew, that it was approximately 4,000 a year who were in treatment. I don't know if there are any figures anywhere as to what there is - I'm not sure, in his own service at the time I think it was about 400 a year were being treated with BPD. So it's an estimate.

You could take a prevalence of 4 per cent, and that would still give you under 2 per cent getting treatment. And there are arguments about what the prevalence of BPD is as well, because the data used here is based from 1980, I believe, the last time there was prevalence data on BPD in Australia.

You'd know that if you look at some of the data that's collected, the national data that's collected, we will have data on bipolar, we'll have data on schizophrenia; there is no specific

data on BPD, in spite of its prevalence, in spite it's a serious and complex mental illness, and the effects that it has in not being treated.

MS ABRAMSON: I have one further question. We've got our recommendation about encouraging interaction between mental health professionals and people with lived experience, away from the healthcare model, and on an equal footing. Do you think that that would help address the stigma issues that you've been talking about? And you know, your comments about the privilege model.

MS MULLEN: My experience is that peer workers within the system in Victoria are constrained within the system that they work. I'm personally very harsh and critical and I see the medical model as patronising, as hierarchical in structure. And that those wonderful people with extraordinary experience and news don't see quite the importance or the significance of what I would call social support and relational support.

And I am loathe to speak more to that, because I am loathe to.

MS ABRAMSON: No, no, I understand.

MS MULLEN: So I don't see it happening now. I think that our system is broken; I think we need a paradigm shift in thinking; I think that the shift in thinking we need to do. And the reason I am speaking now is because of earlier I heard people trying to explain about the medical model and how it was a constraint, and trying to communicate that concept and why that is seen to be so, by - I referred to Marie Piu from Tandem, and prior to that, from Mind - trying to talk to that, and finding it difficult to explain, which is why I've tried to do it with this reference to privileging and seeing it from that particular perspective.

So I'm not confident that it will change. Stigma discrimination would change, in particular with education within the mental health professions and the mental health workforce; it would change when BPD is able to be counted as a distinct disorder amongst the data; it would change when there is research done into such stuff as prevalence; it would change when we stop arguing about what the name of the disorder is.

It's often described to me that in Victoria in particular, we are dealing with a famine mentality for funding, and so it would change when mental health organisations are able to work collaboratively together, without having to be worried about where their next lot of funding is coming from. It's from all sorts of sources.

MS ABRAMSON: Thank you. Harvey?

PROF WHITEFORD: No, that's fine. Thank you.

MS ABRAMSON: Thank you so much.

PROF WHITEFORD: Thanks very much.

MS ABRAMSON: Thank you.

MS MULLEN: Thank you.

MS ABRAMSON: I can now adjourn the proceedings for the day, and we're reconvening 8.30 tomorrow. And thank you very much for your attendance today.

**MATTER ADJOURNED UNTIL
TUESDAY 19 NOVEMBER 2019**



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

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

TRANSCRIPT OF PROCEEDINGS

AT LEVEL 12, 530 COLLINS STREET, MELBOURNE
ON TUESDAY 19 NOVEMBER 2019

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PROF KING: Good morning. We'll recommence the public hearings into the release of our draft report on the Productivity Commission's inquiry into improving mental health in Australia. Again, just to introduce myself, I am Stephen King. My fellow Commissioners on this inquiry, Julie Abramson and Harvey Whiteford.

I'll just summarise the opening statement because we don't need to make the full opening statement again. These are a continuation of yesterday's hearings. Before beginning today's proceedings I would like to acknowledge the Wurundjeri people who are the traditional custodians of this land on which we are meeting, and pay respects to the Elders of the Kulin nation, past, present and emerging. I extend this respect to all Aboriginal and Torres Strait Islander peoples in attendance today.

As mentioned yesterday the purpose of this round of hearings is to facilitate public scrutiny of the Commission's work and to receive comments and feedback on the draft report.

This hearing in Melbourne is one of many around Australia, in all the states and territories, in both capital cities and regional areas. We will then work towards completing a final report to present to the government in May, having considered all the evidence provided in the hearings in submissions and other informal discussions. Submissions and comments to this inquiry will close on 23 January.

Participants and those who have registered their interest in the inquiry will automatically be advised of the final reports released by government, which may be up to 25 parliamentary sitting days after completion. We like to conduct all hearings in a reasonably informal manner but I would like to remind participants that there are clear structures in our legislation for how these hearings are legally backed and a full transcript will be 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. And, again, just a reminder, the microphones are for the transcript. They don't amplify your voice.

These proceedings are live streamed. You can wave to YouTube. These proceedings are live streamed on the Commission's YouTube site. Would be interesting actually to go and have a look at the YouTube analytics and see how many we've got. Sorry, that's not in the opening statement. All participants who have registered to be here at this hearing have confirmed their understanding that they may be visible or audible online. If anyone here has queries about this or does not wish to be visible or audible online please approach one of our inquiry team members here today or feel free to leave the hearing now.

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 that their remarks are not defamatory on 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 and use the visitors' rooms next to the disabled toilets. Bronwyn will be here, so if at any time you are feeling distressed please approach one of our

staff who will assist. We will also have with us Bronwyn Williams who will be available to provide psychological support.

In the unlikely event of an emergency requiring evacuation of the building, the exits are located directly in the hallway that you would have come through between here and the lift. Upon hearing the evacuation tone please leave the building and assemble at the grassed area on Bligh Street. Unless given an alternative assembly point by the fire wardens your assembly point is Enterprise Park. If you require assistance please speak to one of our inquiry team members here today.

And our first participant today is Dr Suresh Marcandan. Please come up. And if for the transcript you would be able to state your name and your affiliation and then make any opening comments.

DR MARCANDAN: Good morning and thanks for the opportunity to present at this hearing. My name is Suresh Marcandan. I'm the managing partner of People Power International, a management consulting firm in Melbourne.

I returned to live in Melbourne after 25 years in Asia, in six countries in Asia, and therefore one of my objectives today is to draw on the experiences and learnings from those countries. I'm neither a medical practitioner nor a mental health expert. I'm a social entrepreneur with a deep interest and passion for alleviating human suffering in mental health preferably through education.

I must hasten to add that because of time restrictions I have not had the opportunity to go through the entire report but I have gone through the summary report and my observations are based on that. I must also emphasise that I am a great advocate of the systems thinking school of thought and most of my observations are based on a systems thinking approach and holistic approach to problem solving.

In my consulting business as well as in my community service activities I focus a great deal on complex and pluralistic social problems and challenges to which we deliver total solutions in a more holistic manner and from a systems thinking perspective. We believe that for these kinds of problems which are very complex direct intervention is not as preferred as an oblique intervention, what we call a flank attack, which alleviates the very stress, yesterday we heard comments on intimidatory effect of counselling and other mental health responses. We also heard about the stigma attached to it, so one of the suggestions I'm coming up with is a rather oblique intervention to this whole issue. I also see this as a huge national issue which should be tackled at the apex level, at a national level, and therefore we look at a very long-term solution rather than tinkering at the edges.

So the suggestions that I'm making is also very heavily centred on my learnings from Asia in a very oriental perspective to this problem particularly with examples drawn from India and Malaysia and Singapore and Bali where I've spent a lot of time in the last years.

The solutions are aimed at removing stigma, creating a lot of communication and community spirit and especially among the various stakeholders involved in the mental health issues, and therefore what I am suggesting albeit rather out of the box thinking, is that it is time to start

looking at yoga as a means of alleviating mental health issues. I have done a little summary paper on this for the three of you, and I'll be happy to answer any questions.

PROF KING: Would you like this to be a formal submission?

DR MARCANDAN: This is a preliminary submission. I'll be happy to present a formal submission if you feel it is necessary and I'd be happy to answer - - -

PROF KING: It's more for a publication so it can be put up as a submission that can go on the website.

DR MARCANDAN: Sure, that's no problem.

PROF KING: There's not a submission that doesn't go on the website.

DR MARCANDAN: Right. No, that's fine. Basically what I am saying is that contrary to popular myth yoga is not a religious ritual. Through the combination of various breathing techniques and postures it is a tried and tested tool for achieving perfect alignment, absolute harmony, and complete synchrony with that existence. My take on this is that mental health issues stem from a lack of control of body and mind and energies within you, therefore the challenge is to ensure that you have your personal mastery and confidence which will alleviate - or enhance your self-esteem. Quite often a lack of self-esteem, low morale, et cetera are caused by social or economic problems and this is an excellent way if it's fun it targets the very large base, so you can administer this to a wide range of people. It can include care givers, health care professionals, so for instance one of the examples I've quoted is that the Prime Minister of India has now made it mandatory for it to be embedded in the school curriculum so that even at that early stage they're able to take control of their mind, and therefore it has although I do not have immediate data to substantiate the outcomes, I'm aware that social ills and various other issues have reduced dramatically after the introduction of that. It is being tested in Sri Lanka, Malaysia and others and it's also in Bali. It is very widespread. I'll be happy to answer any questions.

PROF KING: Yes, Dr Marcandan, so in some ways I'm wondering whether what you're saying is really that novel. So cognitive behavioural therapy, which is if you like the standard approach for mild anxiety and depression, my understanding is that it's connection with what would - perhaps if you were coming from an Indian background would be considered as a yoga type practice, so issues such as diaphragmatic breathing, what is called mindfulness, which is very close to a meditative - would be viewed in an Indian context as meditation, but in a sense they're all - a number of those are already embedded in what we would call therapy, so I'm wondering is it really that you're saying we need more of that or is it that we're already moving in that direction?

DR MARCANDAN: I think there are similarities but a lot of differences too. Cognitive therapy, et cetera, one-on-one more clinical approaches, these are more community based attack the core of the problem and therefore less intimidatory and involve more participants, so they can, you know, be spread to a very wide audience and include all different stakeholders, so it's far less intimidatory, and therefore I do not think they're one and the same.

PROF KING: Okay.

DR MARCANDAN: Cognitive therapy is more threatening and direct. Yoga is an oblique intervention which not only tackles mental issues but general wellbeing and good health and spiritual, body, mind, energies, emotions.

PROF KING: I mean, on the other side we know that physical activity is directly connected. Exercise is directly connected with mental health, so, I mean, again is - coming at it from the other direction is really - is it yoga as such that would be beneficial or is it physical activity, involvement in community, so someone who attends a yoga class or group session with yoga is obviously gaining both the exercise benefits and the community involvement benefits. Someone who goes jogging with a group on Saturday morning or a community run they're gaining the same thing, so is there a difference there?

DR MARCANDAN: The primary outcome of yoga is not physical exercise. It is mental control. Quite often it is made to sound very (indistinct) or a new-aged gym workout for instance. It's not the case. The primary object here for yoga is to focus, train your mind and have control over yourself and also align mind, body, emotion and energy. It doesn't need to be physically demanding, but it is very focused on what it has to achieve and the outcomes decide.

PROF KING: Okay.

MS ABRAMSON: Excuse me - - -

DR MARCANDAN: So the comparison with physical workout is - - -

MS ABRAMSON: Excuse me one moment. I'm sorry to interrupt you. We've got some problem I think with the live stream. We've had people saying they can't - is that - okay, I'm sorry to have interrupted you.

DR MARCANDAN: That's all right.

MS ABRAMSON: Thanks.

PROF KING: Okay. Harvey and Julie, questions, comments?

MS ABRAMSON: I just wanted to ask, and I'm sorry I interrupted you, we've got a proposal in our report about a wellbeing teacher in schools, and I think some of the schools actually do have some mindfulness type training. I'm pretty confident that that's the case. So you're really proposing that the mindfulness that comes from yoga or the benefits of the yoga would be part of something that you might do in schools, and I think you said, is it India that's already - - -

DR MARCANDAN: It is. The current prime minister is pushing very hard for that.

MS ABRAMSON: Do you know if there have been any evaluations of it?

DR MARCANDAN: I'm not - I don't have access to any data admittedly but I'd be happy to look at it.

MS ABRAMSON: It would very interesting.

DR MARCANDAN: I'm not from India. I'm from - - -

MS ABRAMSON: No, no, I appreciate that.

PROF KING: No.

DR MARCANDAN: And neither am I an expert in yoga.

MS ABRAMSON: No, no, it's just that you cited - - -

DR MARCANDAN: It's just that I love the concept.

PROF KING: Yes.

MS ABRAMSON: You cited it.

PROF KING: And cited the - - -

MS ABRAMSON: Well, we would be very interested if there's been any evaluations done of any of the outcomes. Thank you.

DR MARCANDAN: Yes. Well, the point that I'm trying to make is that it has to be systematically embedded.

MS ABRAMSON: No, I understand .

DR MARCANDAN: At all levels. It's not an ad hoc solution. It is a solution that has very long-term implications for mind, body and soul, and therefore it's something that has to be looked at very deeply.

PROF KING: Yes.

MS ABRAMSON: No, no, that - - -

PROF KING: But, again, to make recommendations to government we do need the evidence to show that having yoga imbedded in the system has led to an improvement in mental health.

DR MARCANDAN: Sure.

PROF KING: Yes. Okay.

MS ABRAMSON: Thank you for that.

DR MARCANDAN: Thank you.

PROF KING: Where are we? The next person we have this morning is Angus. Come on down. Mr Clelland, if you can state your name and your affiliation for the transcript and then any opening comment.

MR CLELLAND: Sure. Thank you. My name is Angus Clelland, I'm the chief executive officer of Mental Health Victoria. Now, Mental Health Victoria or MHV is the peak body for organisations that work within or intercept with the mental health sector here in Victoria.

Our aim as an organisation is simply to ensure that people living with mental illness get the treatment and support they need, when and where they need it. This means giving consumers the suite of services that they can choose from, be that delivered in the home, the community or in the hospital setting.

Our broad vision is for a system where people with lived experience, families and carers, are deeply involved in decision making, a system that's easy to navigate, provides continuity of care, a system that's focused on outcomes and a system that's well-resourced to meet current and future needs, a system that wraps around a person and one that responds to whole life needs.

As an organisation our membership is very diverse. It covers community and hospital based services, peak bodies, medical associations and the medical colleges, unions, police and emergencies services, associations, local government housing, homelessness and other organisations, so we have a very broad membership and stakeholder base.

We welcome the PC's draft report and absolutely congratulate you on a job well done. It's a terrific draft report and it's given us an enormous amount of issues and ideas to think about over the coming months I should say. We believe that the work that you're doing will profoundly impact the lives of millions of Australian subject to implementation of course, but we should be optimistic that, you know, change is afoot, and we're seeing, from a national perspective, a perfect storm of reform here in Victoria. We're awaiting with bated breath the release of the interim report from the Royal Commission next Thursday, but of course we've got an aged care Royal Commission, a disability Royal Commission and the potential for a Royal Commission into Veterans and Suicide, so all of these things converging in 2020 make it a remarkable year.

Now, we're particularly impressed with your report's emphasis of governance, prevention, early intervention and social determinants including housing, justice and employment, and we do welcome the opportunity to provide a formal response and we will do so by 23 January as requested.

In the interim we'd like to provide you with a couple of papers that we've just given to the table. One is a joint submission to the Royal Commission here in Victoria, done as a partnership between the Victoria Healthcare Association and ourselves, and a vast number of other organisations, and really that's a whole of sector view on mental health reform in this

state. Of course it's contextualised for Victoria. But of course many of the issues within that document cover the issues that you're covering as well, and really it's a whole of life, a cradle to the grave approach to mental health that we're looking for.

In preparing our submission we'll work with the Victorian Mental Health Policy Network which is a group that we auspice which is 25 peak bodies from around the state that come together every couple of months to talk about policy issues and advocacy issues of course, and we'll provide you something by the 23rd even if that means an early return from Christmas.

Now, in responding to the report, we're still looking in great detail at any of the sections but today we just wanted to emphasise a small number of issues and these relate to older people, planning, workforce, regional autonomy and structural reform, the easy stuff. Now, we understand that the PC hasn't looked in great detail at some of the issues associated with older people, and that's understandable given that we have an aged care Royal Commission underway.

We've been, I guess, a little bit concerned that the Royal Commission itself hasn't specifically tackled mental health in residential aged care facilities or in aged care and we hope that later this year in December the hearings in Canberra, which are about the interface with the health system will cover those issues in great detail.

We have provided you with a copy of our submission to the Royal Commission which draws together a large number of stakeholders including the aged care sector as well. The reason I guess for our concern is that Australia has an aging population. There's at least 15 per cent of the population is over 65, which is to be frank, a bureaucratic and arbitrary dividing line between being an adult and being an older person. I'm not quite sure what that actually means being- if you're no longer an adult you're an older person, but it's the way it works.

The mental health care needs of older Australians are often overlooked and while stigma and stereotypes might tell us otherwise mental ill health is not a normal part of aging and we shouldn't accept that. Those aged 65 and over find it incredibly difficult to access services and be that within the home or indeed within residential aged care facilities. The barriers are particularly high.

We find that older people access the services at a much lower rate than the general population. They find navigating the system very difficult for themselves and of course for their family and carers. They have very high medication rates and we would - many of us would've seen reports about that in the press of course, and at the same time very low MBS services rates relative to the rest of the population.

Many people would be unaware that males aged 85 and over have the highest age specific suicide rate in Australia and it's often overlooked. Now, people within residential aged care facilities and aged care in general rely on aged car staff and unpaid family and friend carers to identify the need for mental health care. This of course has a significant impact on a carer's own health and wellbeing, and their own financial, vocational and educational security outcomes. Aged care staff themselves are absolutely not equipped to respond to the mental health needs of residents and they lack even the most basic mental health awareness training

in their qualifications. It's left to overpaid nursing staff, who are managing very high staff ratios, to take on this responsibility. We advocate for mandatory staff ratios and mandatory mental health training for all aged care workers and this should be embedded within their qualification frameworks.

So moving on from there onto planning, jumping around. We very much strongly support the recommendation 7 that calls on the states and territory governments to determine and deliver the numbers of mental health beds that would meet the needs of each region, as well as providing alternatives to emergency departments.

Picking up on the points of Professor Copolov yesterday we agree that we need more beds and that these should be deployed in a range of settings. We also agree that the investment and community based mental health services and in other areas like housing and employment should ease pressure on EDs. We can't have investment in one without the other.

We draw the PC's attention to the Victorian Royal Commission report, page 22, which details principles for, I guess, a new approach to community mental health care that we're advocating here in the state. Consumers should be able to choose from a range of services delivered online, in the home, and in community mental healthcare settings, and community services such as mental health centres that have been raised and are currently in pilot need to be highly visible and accessible and we see these as a really important aspect of, one, addressing a service need but also helping to reduce stigma and normalising seeking help within the community.

The question for us of course is that we need a strong focus on these sorts of services while we wait for the big ticket items that - like housing and hospital bed based services that take a long time to plan and deliver, and we expect this of course will take many years. The question is it then becomes how much do we invest and where that sweet spot is, and if the PC can provide some modelling in relation to how much to invest and where and what impact that would have on the emergency department presentations that would be very welcome.

Moving quickly to workforce we'd very much welcome the recommendations around the national mental health workforce strategy and the recommendations regarding psychiatrists, mental health nurses, peer workers, as well as training for GPs. These are all critically important. We would emphasise of course that the mental health workforce is much broader than that and of course we include social workers and occupational therapists, psychologists and many others who are critical parts of the system. We concur with the points raised by Robyn Hunter, the CEO of Mind Australia, yesterday, in relation to the community mental health sector workforce. We need to recognise that the workforce is a key risk to any reform. There simply aren't enough qualified and experienced people available or willing to specialise in mental health, and part of the challenge for us all is to make mental health a desirable profession.

Moving quickly to planning, we very support much local tailoring of services to best meet the needs of consumers, but we are a little bit concerned about the recommendation around PHNs being able to redirect funding as they see fit. I'm referring to 24.2. Within the state here in Vitoria we've got at least 22 commissioning bodies if you include the PHNs plus the area health services, and by example if we look at psycho-social support services that creates

enormous variation from region or sub-region to sub-region throughout the state. We would like to see a fully resourced suite of national core services tailored to local conditions that are available to all consumers. That includes things like Headspace and psycho-social rehabilitation services.

Finally, moving to governance, we absolutely agree that structural reform is necessary and support recommendation 23.3 that governments should work together to perform the architecture of Australia's mental health system to clarify roles and responsibilities and incentivise governments to invest in those services that best meet the needs of people with mental illness and their carers.

The pooling of funds through a single body is at first glance a very attractive option for us and as I mentioned with those commissioning, so many different players commissioning, or should I say tendering, services across the state, the efficiencies associated with pooling and the approach of taking a whole population approach would be very useful for us. Within our Royal Commission submission we've called on the establishment of an independent Mental Health and Wellbeing Commission for the state. Victoria lacks a Mental Health Commission. And the scope would be to span the whole of population mental health and addiction and provide independent monitoring and oversight of the entire system. Part of the challenge that we have faced here in Victoria is that there's no single body overseeing the entire population and all parts of the system, and that's a great challenge for us.

So just in conclusion, on behalf of Mental Health Victoria and its stakeholders we'd like to thank the PC for producing such a comprehensive and thought provoking draft report. We very much look forward to providing a more detailed response by 23 January and look forward to the final report. Thank you very much.

PROF KING: Thank you, Angus. I'll start with a question relating to the regional autonomy of the service providers and then pass over to my colleagues. I guess where we've gone in our report is to say well, you need different services depending on the localities and we had examples yesterday of the differences between Coburg and Box Hill here in Melbourne.

MR CLELLAND: Indeed.

PROF KING: Rather than saying well, there is a specific set of base services, so I'd like to understand what you mean by tailored to local needs. That's the first question, but I'll put another one in. Our approach to which services has been they should only be evaluated services, so the aim that we get to in the five or 10 years is the NMHC is an evaluation body which has evaluated relevant programs - - -

MR CLELLAND: Sure.

PROF KING: And the local commissioning authorities then say, well, we haven't got carte blanche. We have to choose between those programs that have been shown to be effective but we need to choose for our local community. So I'd like to get your feedback on, you know, where you see the weaknesses or strengths in that and when you say, "tailored to local conditions", that I must confess - I'd like to understand what you're getting at, and you might want to use Headspace as an example, but given that you're not - - -

MR CLELLAND: Talking for Headspace.

PROF KING: Yes, I'm more than happy for you not to do that, but I would like to get a better view of what you mean by that.

MR CLELLAND: I guess we're possibly using different language to describe some of the same things, but we'd see a suite of services like care coordination, for example, being a core service that's available to anyone that needs it. The way it would be delivered would vary depending on perhaps the location or indeed the group that you're talking about. So it might be done in a different way for CALD groups or LGBTIQ groups, but at its base it's a care coordination service, and absolutely all of these things have to be evaluated and, you know, shown to provide the benefits that we're after. It's that focus on that outcome rather than the input side of things. So we would like to be able to say to anyone within Victoria, indeed nationally, that regardless of where you are you would be able to access care coordination, and it might be services in the home, it might be sort of youth related early psychosis support and so on. The way that that gets delivered locally would vary of course, but at its core it's a set of services that everyone can access. Does that make sense?

PROF KING: Yes. And I will push you a little bit further on that because you did mention in your comments Headspace, and Headspace is currently - PHNs are directed to fund Headspace centres and we've said, well, that sort of direction we don't consider consistent with a model of regional commissioning for local needs, but I assume you disagree with our position on that, so - - -

MR CLELLAND: Yes, look, the - it's all about, I guess, giving that right balance, and as a state we see extraordinary variation across regions in terms of what's delivered, and that particular model providing so much autonomy over decision making I think is counter-productive and getting the balance right I think is what we need to approach. I don't - - -

PROF KING: You need a simple direction then.

MR CLELLAND: Yes, and we've played around with terms like with consistent set of services but, you know, with local variation, those sort of things. But I think this is going to be one of the big challenges for the government's reform getting that balance right.

PROF KING: Okay. Thank you.

MS ABRAMSON: Mr Clelland, thank you very much for presenting your evidence in such a clear and concise way. That's been really, really helpful.

MR CLELLAND: Thank you.

MS ABRAMSON: I wanted to ask you two questions.

MR CLELLAND: Sure.

MS ABRAMSON: The first one is you made a very helpful comment about what you saw

as national core services, and one of the things that we thought a lot of in the report is who does what, Commonwealth or State, and there are some programs where the delivery of suicide prevention strategies we thought there was a role for national - rollout in national government. Very interested in understanding what you think might come under a banner of national core services.

MR CLELLAND: That's a terrific question.

MS ABRAMSON: Happy to take on notice. Yes.

MR CLELLAND: We'll take that on notice, and this is a subject of great debate amongst the stakeholder groups, but we will take that on notice and provide back an opinion on that.

MS ABRAMSON: That would be very helpful. Just - - -

MR CLELLAND: I guess - sorry, just to add to that, so long as they're funded and they're done well we're not concerned, I guess, but we'll do some work on that.

MS ABRAMSON: Yes, I suppose we're - thank you for that - where we're coming from is that we think, well, what makes sense to deliver one type of program across the whole of Australia and - - -

MR CLELLAND: Yes.

MS ABRAMSON: - - -that's in suicide prevention. We thought that that was valid, but there may be other services as well. The other thing was you made some interesting comments about the Victorian - about Mental Health Commissions, and in our draft report we concentrated on the National Mental Commission because we did see that each of the states had slightly different models. So I'm just interested in you expanding a bit on what you said about the Victorian situation.

MR CLELLAND: Yes, I guess we've come to this I guess before and produced, you know, our submission back in July in relation to the Royal Commission. One of the key gaps from a government's perspective within a state from our perspective is lack of an oversight body that can monitor, report independently to Parliament, act as watch dog, and to be frank, to snap at the heels of government when need be to make sure that what reforms are agreed are delivered and done particularly well.

We are quite interested in the model that's being developed within New Zealand which brings together the concept of wellbeing but also alcohol and other drugs to bring together those two streams that are approached as very separate silos, at least here in Victoria.

From a national perspective if we go down the path of a beefed up National Mental Health Commission, and I guess the question for us is, is there necessarily that need at a state level for such a body, and it would be ideal if we had one national body that could oversee the entire population and provide, you know, the right direction and so on that's been identified within your reports. So it's a really fascinating question, so - - -

MS ABRAMSON: We'd welcome your comments on that. I suppose two further things I'd ask you, evaluation of programs, that's something that we've seen as something the revamped National Mental Health Commission could do, so when you're thinking about the State Commission you might want to turn your mind to that and also it's very interesting what you said about New Zealand so we'd welcome some more information on that.

MR CLELLAND: Sure, we'll take it on notice. Thank you.

MS ABRAMSON: Thank you very much.

PROF KING: So I think the questions have been asked really. So just clarifying the support from your position in Victoria is that mental Health and addiction services are delivered together as part of a single suite of broader mental health services and not separate?

MR CLELLAND: That's right. Yes.

PROF KING: So when it comes to, I guess, population level substance use services more broadly, is that part of that suite of services if you understand what I'm asking there?

MR CLELLAND: Could you elaborate just a little?

PROF KING: So where we're talking about where alcohol is sold across Australia for example issues about, you know, national use of - certain substance uses and their restrictions legally varies from state to state so in a national approach thinking through how that would play out at a local level where we're talking about, you know, a regional commissioned authority or - the balance between whether it's just the clinical services or the psycho-social supports for the location population versus the bigger picture which often surround alcohol and other drugs.

MR CLELLAND: I guess there's a role there at a local level and at a national level. I'm sort of thinking through this as we speak. In terms of service delivery on the ground for the consumer for families and so on, absolutely there should be an integrated suite of services that can be accessed. In terms of policy making at a national level I'd expect that such Commission would be heavily involved in it, but I don't really have a view about where the actual policy making occurs, but it's something that we can have a look at.

PROF KING: Thank you. That's all then. Thank you very much.

MR CLELLAND: Great. Thank you very much.

MS ABRAMSON: Thank you very much.

MR CLELLAND: Cheers.

PROF KING: And next we have Mr Rosevear and Mr Davies-Kildea from Beyond Blue. And if you would identify yourselves and your organisation, despite the fact that I just did that.

MR DAVIES-KILDEA: Sure.

PROF KING: For the transcript and then if you've got any opening comments you'd like to make.

MR ROSEVEAR: No problem. So, I'm Sam Rosevear, the general manager of strategy and policy, Beyond Blue.

MR DAVIES-KILDEA: And I'm Jason Davies-Kildea. I'm head of policy and advocacy at Beyond Blue.

MR ROSEVEAR: So we've got four core messages for you today and the first is just a hearty congratulations from Beyond Blue on what is a really strong and comprehensive report that would undoubtedly lift the mental health of Australians right across the country. We think this is fantastic, and we'd highlight your emphasis on the early years, the emphasis on low intensity support, recommendations for universal aftercare involving consumers and carers in all aspects of the development of mental health policy and design and evaluation, building the peer workforce, a national stigma reduction strategy, strengthening the role of the National Mental Health Commission, and I could go on and on. A fantastic report. Thank you, from the bottom of our hearts.

But today of course is about how can we make the report even stronger and so we're going to try to give you some actionable clear recommendations that we would suggest, and there are three areas. The first is an even stronger focus on prevention, and no doubt you're thinking, "Didn't we throw the kitchen sink at that?", but we think you can go even further. A second is a bolder program of structural reform to underpin the low intensity sector, and the final one is putting a bit more prevention into suicide prevention.

So, firstly, just to prevention, we think if you're going to change the incidents of mental ill health in Australia that just as with physical health prevention is overwhelmingly the key. We live in a country where too many people are experiencing adverse childhood experiences which are responsible for 16 to 33 per cent of anxiety, depression and self-harm in adulthood, and we know that, as you rightly point out, 50 per cent of mental health conditions are arising before the age of 14 and 75 per cent before the age of 25, and partly as a result we've got half the country, or almost half the country experiencing mental health conditions in their adulthood.

So the holy grail of mental health is preventing that happening in the first place, and we've got three areas we think we can do more. The first is equipping parents who are the strongest influence on children's social and emotional wellbeing to raise thriving children. The second is equipping educators to create mentally healthy learning communities that support children. And the final one is equipping workplaces so that workers are placed where our 13,000,000 workers can thrive and contribute.

And to just talk a little bit more about each of those, firstly, we really acknowledge that the Commissioner has given great emphasis to the early years including universal screening and expanding parent education programs in child and family health centres. However, we think a signature initiative, perhaps the signature initiative of the report should be to recommend

that Australian and State Governments work together to build and systematically fund a comprehensive national system of support for children naught to 12 and their parents.

The reason for that is, as I describe, it is the biggest issue to change the trajectory of Australia's mental health. We know that a system barely exists to support parents to raise thriving children. The National Mental Health Commission in their landmark 2014 reform report stated:

There remains a critical gap for children aged from birth to 12 years both for the child and for parents who need to be supported to maximising their child's development and wellbeing.

So it's the biggest issue, and we don't have a system to do something about it. And we know one in seven kids aged four to 11 are having problems and less than half are getting help, and we know that parents often don't have the knowledge to support their mental health, and as a parent of a seven year-year-old I can say I could really value more advice and support to raise a thriving child at each stage of the transitions for kids. So we think there's no greater priority than this, and we can talk more in conversation about what that might look like.

Our second prevention idea is that we agree with the Commission wholeheartedly there are too many frameworks and too many programs in schools leading to confusion but we feel like the report stops short of them nailing the answer and we believe the answer is to recommend that COAG education ministers agree to the adoption of a single national framework to support wellbeing in schools and early learning services, and we believe that Be You is overwhelmingly the obvious choice for a number of reasons. Firstly, it was designed to create one clear evidence based framework by joining up a series of successful but disconnected programs including KidsMatter, MindMatters, Headspace, School Support and Responsibility. It's already being funded nationally and substantially. It is the clear choice of schools and early learning centres, so we know that having launched in November 2018 6300 schools have signed on, 67 per cent; 2900 early learning centres have signed on; 90,000 individuals have created learning accounts. We'd also pointed out that this is evidence based, so those programs that it was built on themselves were world leading. One quick quote, an evaluation of KidsMatter by Flinders University found it was:

associated with statistically and practical or practically significant improvements in students' measured mental health reducing mental health difficulties and increasing mental health strengths.

It also accords with the Lancet Global Commissioner's recommendations where they say the most effective universal, social and emotional learning interventions use a whole school approach in which the social and emotional learning and support is supported by a school ethos and a physical and social environment that is health enabling involving staff, students, parents and the local community. This is exactly what Be You does.

I could say more about this but I'll just land on one final point. Be You was developed with and has the very strong support of the key stakeholders including Commonwealth and State and Territory education departments, so we think it's very important. I better stop there.

MR DAVIES-KILDEA: I'm going to take up from there and really take up that theme, I guess, of how bringing together fragmented services programs, information in education is replicated in the workplace sector, and that's recognised well in the PC's interim report. I think there's a great contribution that's been made by the report in addressing the risks particularly around workplace mental health, and if there's any room for improvement it's more around the emphasis about the opportunities present, and I think that is a place where so many millions of Australians are. The opportunity for having mentally healthy workplaces as a probative proactive contribution to population of mental health I think could go a step further.

Certainly it's recognised that workplaces are seeking direction. They're looking for opportunity and there's a multitude of, you know, potential places of information here. What was missing, I guess, for us is recognition of the national mental health workplace initiative which was funded in this year's Federal budget, and it brings that opportunity to pull all of that together from a national level. It's led by the National Mental Health Commission and supported by the Mentally Healthy Workplace Alliance, so already it's got in place the foundational funding that will be required to bring some of this together, and it builds on an established collaboration of diverse interests from unions to, you know, employer bodies, government mental health as well. So I think there is a lot more that can be done in recognition of what's begun already and has momentum and in fact to potentially begin that again creates some other risks.

MR ROSEVEAR: So now to stronger structural reform to underpin the low intensity sector, so we thought it was great to see the Commission recognise stepped care and also the importance of low intensity and we love the estimate that 450,000 people currently being served through Better Access could be served through low intensity. We think that's an incredibly important finding. And we also like the fact that you recognise that low intensity support is the need for the vast bulk of the population and yet you have a service system that's very much in its infancy and is actually quite tiny.

So we think there's four elements of structural reform that it'd be worth giving further emphasis to. The first is the micro-economic foundations of the sector. So, for example, all sectors need good education and training pathways in workforce development. If you're trying to develop a program in low intensity services at the moment you have to drive those often from scratch. We need a comprehensive system of accreditation of services, so consumers can feel confident that they are drawing on evidence based interventions. Consumer awareness as the Commission has recognised is a real issue that we don't have a national culture of taking up low intensity services, so we need to inform consumers that this is something that can benefit them. And, finally, the linkages to the clinical system are obviously seminal important. If GPs think that the two options are medication and Better Access then they will continue to use those options and low intensity will struggle to find a foothold.

The second area for structural reform is meeting demand and need long term, so it was great to see a recommendation around 150,000 additional places, but the report says there's 450,000 people who would be better off, not Better Access but low intensity, and we also know 5.8 million Australians are at risk and 2.2 million Australians have mild mental health conditions, and 1.1 million Australians have moderate and 60 per cent of the population are

well and hoping to stay that well, and all of them would benefit from low intensity support. So what is the pathway and the mechanisms, the funding mechanisms and the governance that's going to lead to a low intensity support system to arise, and that needs to be addressed.

The third issue that we think is important is structural reform in low intensity is national funding. So if we're trying to from a situation where we have a radically under-funded too small system then regional commissioning, though absolutely seminal, and with a terrific place in the system, is not going to get the job done. We need to be able to nationally fund the expansion of services. So some of the great recommendations you've put in the report including 150,000 more places and universal aftercare. If that's going to come to pass the best way to do it is through national funding mechanisms. Requiring service providers to go across 31 different Commissioners is not an easy way to create national services. It makes it really difficult to get the economies at scale that reap the cost benefits that are the promise of low intensity.

Furthermore there is a serious institutional failure at the heart of mental health funding in our country and it's this, you've got basically demand driven funding for the clinical system, so we've identified that the funding for Medicare subsidised clinical mental health services they've gone from 351,000,000 in 2006/07 to \$1.2 billion, almost a quadrupling by 2017/2018. Meanwhile low intensity support is heavily capped and capped at a rate that will never allow a major system to emerge.

So what you have is a system where the minority of the population needing clinical support has demand driven funding which is going up in gangbusters whilst what most of the population needs is heavily, heavily capped at a rate that would never allow a system to emerge in anything like the scale that is needed. So this is an institutional failure that I think is right up the PC's alley in terms of the sorts of thing you're so effective at solving and we think you need to give that consideration.

Our fourth area and final area in relation to low intensity structure reform is expanding the full suite of evidence-based interventions that consumers want not simply clinician supported online to the. So we know that consumers want a mix of coaching through various modalities face to face, online and over the phone and international best practice in the Lancet Commission highlights that much of the value of low intensity services are not about being clinician supported and clinician run. If low intensity means clinician supported we are going to have got out an enormous cheque book because either taxpayers are going to pay or consumers are going to have to be asked to pay many of whom will be turned away by the price tag.

The big promise of low intensity are alternative workforces, peer to peer support, coaches providing help for people with mild to moderate depression and anxiety, support coordinators helping people with after care after people have tried to take their own lives, and wellbeing staff supporting children in schools are just some of the examples. Now, the important thing here is not that they're clinicians themselves but that they're clinically supervised and effectively trained and that there's evidence that the programs work.

Can I say I thought it as a bit un-PC like to say, 'Let's back this one modality'. (indistinct) more central planning in orientation than what I see the PC normally advocating which is

more about giving consumers a choice and developing a market of options, some which are relatively higher cost but provide more intensive support, others which are lower cost and in that way meeting the needs of the whole community.

And just finally, you did have an information request 5.1 in relation to CBT coaching and I'll only just make some preliminary remarks which are CBT coaching including innovate access to psychological therapies in the UK and NewAccess is a proven intervention which delivers powerful recovery rates and it is cost effective at scale. We're all in agreement it's effective so NewAccess delivering 70 per cent recovery rates is pretty remarkable and we were delighted to see the table on page 223 of the report which showed NewAccess delivering the highest benefit in terms of impact of all the interventions in that table noting that a number of them actually hadn't been evaluated.

So the issue now comes down to cost effectiveness and we'll provide, as we have previously, information showing the staff costs at scale are lower, the training costs are lower and of course the foregone costs to participation of being people out of the workforce for very long periods of time doing training are very much lower. Thank you for enduring that part of the low intensity but that was the one thing we felt strongest about. We'll just talk about suicide prevention and then open it up.

MR DAVIES-KILDEA: So just very briefly. Look, we certainly very strongly welcome the recommendation about universal after care, I think it's a fabulous recommendation and much needed. I guess our hope is that we could push it ever further along the continuum of suicidality to provide more support to people long before they've made an attempt to take their own lives. So there are some elements in that which I think are really promising.

The alternatives to emergency departments for instance are really important. I think there could be more space potentially for those to exist, you know, beyond even the hospital grounds at the point at which we've already kind of, you know, medicalised the solution or provided that particular context, there could be further opportunities. Co-responder models building the peer workforce are all great kind of interactions.

And we certainly support, you know, the range of trials that are currently happening in terms of suicide preventions, systems (indistinct words) is excellent. Within that, how do we ensure that we continue to kind of push back along that spectrum to the earlier points where rather than, you know, within hospitals and clinical situations we can support people within the community and potentially even supporting people right back to their own homes where they're in a safe environment to do so.

We've looked at a range of things from the brief intervention that's being trialled in Scotland, for instance, which connects a range of gatekeeper roles and really those first points of contact with support at the back end, for people who are experiencing all forms of distress that might initially be identified by them or others as suicidal but can lead to that without the right kind of supports; we think those are the things right along the spectrum of safe space as to anyone who needs them with supports backed up whether that's for respite or whether that's to provide safety and need and to kind of get the collection of support around you to ensure that you're in the right space for recovery. I think that will do us to begin with but

really happy to answer any questions. We will be providing a detailed response as well in January.

PROF KING: All right, thank you. Again I'll kick off and then pass to my colleagues. You talked about, you know, equipping parents with a national system of support for children 0-12 and their parents and you suggested that, you know, practical ways to do this we could discuss that, was exactly my question.

MR DAVIES-KILDEA: Sure.

PROF KING: A great idea but what are the practical on the ground recommendations we need to make not (indistinct words) level but once you've said, 'Yes, we want a national strategy and the national strategy needs to make sure it does A, B, C, D'.

MR ROSEVEAR: Sure. This is a difficult question because we're trying to establish a system that doesn't, you know, considerably exist so it's a pioneering exercise but some of the issues that we highlight are: I think there's need for action on three levels. One is the universal primary prevention area; another is early intervention; and then the final piece, and we'll get to the brass tacks in a minute but just the framework, the final is support for families in tremendous need.

So, so many issues around universal primary prevention are really ensuring that parents are ready for the journey before children come along at that, you know, perinatal period because it is such a profound change and their mental health being strong and knowing how to support kids is very important so some of the practical issues including, 'How do you have online support and information for people that is quickly available and readily accessible' and the Raising Children Network is an example of something which I think is absolutely fantastic. I'm always prone to wanting to talk about healthy families at Beyond Blue but I won't, I'll take about Raising Children Network.

Raising Children Network, you go on to that site and you can see every life stage straight away so as a parent you can go - right, 0-3 or they're about to go to school or, you know, they're in school - and then there's a drop down menu of all the things that you need to do to support your child from, you know, health to mental health to diet to, you know, emerging into the school system and so on. Now, how do we create a culture where all Australian parents actively and proactively invest time to prepare themselves and have the knowledge to support their children? So online support is one really important and practical aspect of this and I commend the Raising Children Network but how can we make that part of the popular culture and publicise that much more strongly?

Another part of this could be drawing on the fact that in private practice there are parent coaches so if you're wealthy enough you can go and get yourself a parenting coach but this is a classic of the low intensity options that we have and that's, 'Could we draw on experienced parents and grandparents who want to give back and arm them with the evidence-based information of the Raising Children Network and have them available to young parents to help them with the raising of their kids?'

There's an enormous need, there's an incredible workforce and there's a lot of evidence, informed information, that can be passed on so there's a range of ways there in that universal prevention space that need to be identified and it's a hard piece of policy work because we're in pioneering territory so you won't have randomised control trials done on 100 countries that show unequivocally that this evidence works. Rather, you're going to need to establish a system that trials things, evaluates them, evolves them, closes them down when they don't work, beefs them up when they do work so that's going to need to be a learning system.

In the early intervention area: so we see, and we put in our previous submission, a number of individual examples of local programs which work that parents can go along to when kids are in trouble and get the support they need both for the mental health of the child but also in terms of how parents can be equipped to support kids with mental health conditions. But they're very small scale, they're very local and there's not coverage across the country so a big question that you'd want to put in there is, 'Australian and State Governments, how can we draw on the best of what exists and make it widely available so we don't have a world where one in seven kids aged 4-11 are in trouble and less than half are getting any support at all?'

And then finally, support for families in greatest need, you know, where significant adverse childhood experiences are prevalent. We know this is responsible for 16-33 per cent of depression, anxiety and self-harm in adults. This is an area too important to ignore and we know we have a system that tries hard and occasionally does well but could be a lot stronger. So they're some of the issues that could be teased out, some of those practical issues that could be teased out and drawn on. We don't think just saying family health services providing more parenting education is enough, there's so much more there that needs to be drawn out and considered and built up to get the comprehensive national system we need.

MS ABRAMSON: Thank you. I've got to questions I'd like to ask but I'd also like to thank you as an organisation for the very constructive and helpful way that you've engaged with the Commissioner so thank you and we look forward to of course that continuing. My first question is about Be You and it's really about the practical support that's available for schools implementing Be You which is of course an online program and I understand that, correct me if I've got this wrong, you have about 70 consultants helping school but there's 6000+ schools so I'm really interested in that type of support and then the second question related to that is also dealing with stigma and getting people to come forward so perhaps if you could deal with those two issues for me.

MR ROSEVEAR: Sure. So the 70 staff are available online and can be available on site and their primary task is to help schools develop mental health strategies which can include, you know, the empowering of the educators through the online material that is available to support the development of teachers so that they can help to raise or help students to thrive to create links to local service providers so an important point about Be You is not the suggestion that it will solve all mental health problems in schools but what it will do mostly is empower and educate teachers to raise thriving kids and it will also enable the development of strategies in schools that bring together parents, teachers and students to underpin the wellbeing of kids.

Now, in terms of downstream support that is not something that Be You does in terms of providing mental health specialised clinical support, that's a separate issue. Am I answering your question?

MS ABRAMSON: Yes, no it's absolutely fine. It was more the resourcing because we're looking at this, 'Where would be putting the funding and the support?' so we've got the proposal about the wellbeing leader in schools, you could draw on the Be You material but we were just drawing the contrast between the amount of people that you might need to support that program being fully implemented or used across schools, that was all.

MR ROSEVEAR: I think the distinction is that Be You provides the overarching framework for mentally healthy educational communities at what level under which arrange programs will sit. Those programs themselves will absolutely need to be resourced very differently to Be You in the way that it functions.

MS ABRAMSON: No, no I understand. And then the second point was: you will have seen I'm sure when we put what we thought was a modest proposal about screening to assist parents in recognising issues with very young children, emotional and social wellbeing, that we got, you know, some of the criticism around that and that's really about stigma so really interested on your views on that.

MR DAVIES-KILDEA: I reckon the key to screening is around the how it's done. It's what the screening is looking for, how it's conducted - you know, even where it's conducted and who by. So, yes, we're very aware that there is a natural reaction by parents and concerned community members around, you know, the potential stigmatisation, medicalisation, you know, of diagnosing very young children and we would share many of those concerns ourselves, that's not the intent of a screening. But I think there can be some work done and this will certainly be part of our submission around how that screening itself is framed, how it's conducted, to reduce the stigma associated with it.

And I think the other part of it is that the screening itself desperately needs to be connected to appropriate levels of support so if something is identified by a screening then parents, children, carers, everybody has access to ensure that they've got the follow-up they need to ensure that things are on track.

MS ABRAMSON: Thank you. The final question - I'm sorry, Harvey, I've just got one more question. It was really interesting to hear you talk about the low intensity issues so we're quite interested in the workforce: how would you fund that and if you were to fund it from, just in a hypothetical sense, from taxpayer funding; what type of accreditation would you have around that workforce?

MR DAVIES-KILDEA: Look, we're really supportive of the notion of an accreditation scheme and in fact that's something that we've been pursuing and asking questions around what that would look like.

MS ABRAMSON: Is that for peer workers or more broadly?

MR DAVIES-KILDEA: It would include peer workers but not necessarily, you know, be constrained only to peer workers. The way that NewAccess has been rolled out across the country certainly include a range of people, you know, who fit into that peer worker category but go beyond that as well and, you know, we've absolutely seen strengths in that. There's no doubt that, you know, being clear around the skill base, the methods that are used in low intensity CBT, the evidence base behind that to give the clinicians who refer people into those courses of treatment, you know, really have the confidence needed because, you know, it very much is related to scale and ensuring that that very large group of people with mild conditions don't progress further down the track means you've got to be able to effectively intervene.

I don't think we have all the answers to the kind of accreditation yet, part of it may relate to peer workforce but as I say it can't be constrained to that but we'll certainly look forward to kind of engaging in further in what that might look like and collaborating in terms of how that might roll out across the country.

MS ABRAMSON: Thank you, and I'll get you to take on - I notice, Michael, that my colleague will have some questions - the barriers at the moment which are preventing taking up that low intensity model, thank you?

PROF WHITEFORD: Thank you, so one question again about CBT coaching. So you can see from our information request that we were looking for more information. I think one of the key phrases you had was 'at scale'.

MR DAVIES-KILDEA: Yes.

PROF WHITEFORD: So the cost effectiveness at scale, can you just talk a little about how that might demonstrate a different outcome to what we've got now as far as the cost effectiveness of the roll out of the program for all CBT coaches?

MR ROSEVEAR: Yes. I think whenever you have a pioneering service, and there are many examples when it starts up the scale is low and the fixed costs are high so at a certain point you're always going to say, 'Oh that doesn't look right' but that's not the question that we should be asking. The question we should be asking is, 'If this was a seminal part of our low intensity system, 20 times more people in the UK get access to IAPT than get access to NewAccess and with 560,000 people in the UK getting that access it's heavily more cost effective so we don't think it's fair to say at a really early point in the process as you're trying to develop this system with low scale the costs look a bit high, done and dusted, CBT doesn't work. As you've identified it gets fantastic results so 70 per cent recovery rate is fantastic. We'll give you some information and some analysis that shows that if you could get it to a large scale, which has been done in the UK and can be done here, that the costs are pretty useful.

PROF WHITEFORD: So just push you a little bit hard on it. So one of the challenges in the IACT is the term - - -

MR ROSEVEAR: Sorry, the term of the trainers.

PROF WHITEFORD: That's right and the people who are the providers. If they move on from IACT or CBT Coaching Australia to other roles and we have to constantly retrain them; is that going to be a limiting step or how is that being tackled in the IACT program in the UK that you're referring to so when you got to scale that term of the trainers does it become less or how do we handle that?

MR ROSEVEAR: Well, if you're talking about the costs of training, the costs of NewAccess training is about \$17,000, the cost of training a psychologist is \$25,000-\$30,000 a year for four to eight years so if we're comparing like with like we're happy to have the conversation about training costs.

MR DAVIES-KILDEA: But in terms of the workforce I think it's really, you know, unclear at this point because we haven't reached anything near scale, people who move on from that workforce are about what are the connections to other workforces and how is their satisfaction in their current role, you know, actually working out?' I'm not sure necessarily that the NHS in the UK and where we are in Australia gives us the exact comparisons we need to say, 'What's happening over there?', you know, (indistinct words) yet? Maybe it is but we actually won't, you know, be really clear in terms of our ability to assess that until we've got much closer to the scale and how the low intensity system fit in with the other parts of the mental health system.

MR ROSEVEAR: But I'm hearing your issue is, is there too much turnover in CBT coaching? Is that - - -

PROF WHITEFORD: Well, that's one of the issue in relation to that so we've got to - there's no doubt that it's got a place from what we've heard, the question is, 'Can we grow it to the scale that we think it might have?' - I mean, if we do, how do we have the workforce to support that because the cost of replacing that workforce continually, if that's the issue, might add to the cost of the program.

MR ROSEVEAR: Yes, so your two big issues are around the turnover and around the ability to move it to the scale that you would then get the cost efficiencies?

MR DAVIES-KILDEA: That's something we can have a look in - you know, within our own context in trying to work with our partners in delivering this to understand better is our experience in Australia so far comparable to the UK although again it's still and experience that at the moment is at a relatively small scale.

PROF KING: Can I follow up on exactly that same question because you pointed out quite correctly that it's unusual for the Productivity Commission to say, 'Ah, well this is modality for low intensity services' but at the same time you've mentioned the importance of scale. If you had five or seven (indistinct words) national programs and the problem is if only one/two or maybe even three would possibly reach scale then you may be by saying, 'Let's start off with (indistinct words)' you may in fact (indistinct words) none of them to be able to reach scale so at some stage if you were having a national program the national delivers in charge of that has to say, 'Right, well the evidence says these are the one, two or three best programs (indistinct words), we'll see how consumers choose, we'll see which of those gets to scale and maybe we'll end up with two in five years' time but - - -

MR ROSEVEAR: We were convinced by the Commission's own analysis which said, 'Consumers or people want choice' Some people want on the phone, some people want face to face and some people want online. So if that's your analysis and we've got programs that can fill those options, then I would have thought recommending expansion across a small suite of programs that meet the needs of consumers in those three areas would be the way to go rather than just having the one method and of course you can go out and find out what is evidence-based and have people demonstrate cost effectiveness and ability to scale and all of those sorts of things can be built into program design.

MR DAVIES-KILDEA: I'd say also that, you know, we certainly don't have a problem with clinicians (indistinct) online treatment. I absolutely agree that at the low intensity end that has to be a major part and, you know, 150,000 people going into that kind of treatment seems to me to be entirely appropriate. The question is, 'What about everybody else?' and your report has quite rightly pointed out some of the limitations of online. You know, 2.5 million Australians without access to the internet still, you know, people who have technological illiteracy issues and there are other kind of (indistinct words).

There are a whole range of constraints where people cannot actually, regardless of the choice factor which should be there anyway, get the benefits that they would want and they need from online therapy so it's not a matter of, you know, the gap between 1 and 7 necessarily but we just want to kind of expand it more clearly in the share of need which, you know, it's certainly recognised that it's at least warranted in 50,000 Australian.

MR ROSEVEAR: And if the volume is so high that you envisage expanding at least 450,000 let alone the 2.2 million people with mild conditions, that doesn't seem like a one modality solution, it seems like a range of choice would be pretty fruitful for the Australian community.

PROF KING: Thank you.

MR ROSEVEAR: Thank you.

MS ABRAMSON: Thanks very much.

PROF KING: We might duck out for a toilet break.

MS ABRAMSON: That would be great.

PROF KING: We are going to duck out for a two minute toilet break.

SHORT ADJOURNMENT

PROF KING: The next person is Stephen Carbone. If you could state your name, position or organisation for the transcript and then if you have any opening comments and again just remind people the microphones are purely for transcript not for amplification.

DR CARBONE: My name is Dr Stephen Carbone. I'm the executive director of Prevention United. Okay, so thank you very much first of all for giving me the opportunity to address this hearing. As I said my name is Stephen Carbone, I'm the executive director of Prevention United. I have over 30 years' experience working in the health and mental health field both as a clinician and as a public health professional and also have supported many families members who have experienced mental ill health.

Prevention United is a relatively new mental health promotion charity that focuses on the primary prevention of mental health conditions. My colleagues and I founded Prevention United because we believed there was a major gap in Australia's approach the primary prevention of mental health conditions of mental disorders/mental illness as some people call them and by that I mean preventing conditions like depression and anxiety disorders and others before they start.

Our organisation focuses on three main areas: awareness and advocacy; providing prevention information resources for the public; and capacity building for organisations wanting to increase their focus on the promotion of mental wellbeing or the prevention of mental health conditions. We'd like to congratulate you on your comprehensive reviews. We particularly welcome the Commission's recognition of the importance of prevention in the mental health field.

Mental health conditions are not inevitable and many conditions such as depression can be prevented from occurring in the first place. That doesn't mean we can prevent every case of depression from occurring just like we can't prevent any case of cancer from occurring but prevention is possible. We therefore strongly agree that this needs to be reflected in Australia's mental health policy. Our only concern is that while the draft report does mention prevention and makes several very important recommendations that will contribute to this endeavour, in our view it falls short of outlining the full extent of both what is possible but also what is required to prevent mental health conditions among the Australian population.

First, just as a point of clarification, it's our view that prevention is the not the same as early intervention. Prevention, or primary prevention, focuses on stopping the occurrence of a condition while early intervention focuses on early detection and treatment of a condition that has already developed. Preventing mental health conditions requires a public health approach. While early intervention is largely a mental health endeavour requiring access to clinical and psychosocial supports and services, a public health approach is an approach that focuses on groups and communities rather than the provision of one to one services.

It seeks to influence the underlying root causes and the upstream determinates of mental health conditions, that is risk and protective factors rather than treating the condition, it does this by supporting individual behaviour change as well as improving the social environment around people. It therefore requires multi-sector action most of which needs to occur outside the mental health system in the home, education settings, workplaces, local communities and online to mention a few.

Its tools include public education social marketing campaigns, personal skills building programs such as parenting programs and resilience programs, the creation of mentally

healthy organisation environments and mentally healthy public policies; we need to put policies in place to tackle some of the underlying risk and protective factors. So it's really a mixture of campaigns, programs and services rather than clinical and psychosocial supports and services.

At present most of the mental health funding in Australia flows to mental health care and substantially less flows to prevention. As a result I do not believe that Australia has a prevention system that is sufficiently robust to seriously reduce the incidents of mental health conditions in the community but we can create one. Instead what we have is a series of largely disconnected prevention initiatives that target some risk and protective factors but not others, in some settings and not others and rather than a coordinated and systematic approach to prevention in the mental health field as we try to have in other parts of the health field, therefore while we support many of the recommendations in the draft report we do not believe that this is all that could or should be done.

Yes, we urgently need to scale up some of the known evidence-based prevention and intervention mentioned in the draft report but we also need to build a strong prevention system or really what we should be building is a strong mental health promotion system that can focus on promotion prevention, suicide prevention and, you know, some of the aspects of early detection around help seeking destigmatisation. It is therefore our hope that the final report will put greater emphasis on prevention by including it perhaps in a separate section to early intervention and by setting out more recommendations for how we can build an effective system.

Prevention in the mental health field is both the same and different to prevention in other health areas. The public health principles are the same but the complexities magnified because of the large number and wide range of underlying risk and protective factors that need to be simultaneously influenced, ultimately we therefore need to answer the questions, 'Which risk and protective factors can we tackle using what interventions, through which settings and for which age groups and how will we establish, coordinate monitor and resource this?'

Ideally the final report should therefore outline some of these risk and protective factors. In our view preventing adverse childhood experiences, some people call them 'ACEs', in particular child maltreatment must be a central aim. Childhood trauma, child maltreatment, is the single biggest preventable risk factor for the occurrence of a wide range of mental health conditions and suicidality. It is estimated that preventing child maltreatment would prevent around one-fifth to one-quarter of all new cases of depression and anxiety disorders and also contribute significantly to the prevention of self-harm and suicide.

Another major risk factor that needs to be tackled is social disadvantage. The draft report highlights the very strong association between socioeconomic disadvantage and the expense of mental ill health but the recommendations fail to indicate how governments should tackle this. Ideally the final report would also mention more about the known evidence based approaches to prevention are particularly those that are ready to take the scale. The report mentions some of these including some parenting programs and social and emotional learning programs but there are far more evidence based approaches particularly for schools that

could be used to prevent depression, anxiety, conduct disorder and even substance misuse particularly using CBT strategies.

Again in terms of the settings we totally agree that antenatal services (indistinct words) schools, universities and workplaces are ideal but there are other settings; in the home, place based approaches through local council - what is the role of primary health care in the prevention of mental disorders and what about the online environment? There are also existing organisations that are doing a fantastic job that could be better resources to also focus more explicitly in prevention. Beyond Blue is already doing a lot of good work (indistinct words) but Headspace can also potentially play a bigger role in prevention as well as early intervention.

And ideally the final report should also consider how we would - you know, how it does with the mental health care initiatives - how we would select and implement these initiatives, accredit them, how and by whom they would be delivered and they would be integrated and coordinated as well as measured, monitored and resourced? The report talks about the early years educators/teachers and OH&S personnel but it puts a lot of pressure on those individuals when maybe it's time to employ suitably qualified mental health promotion workers to support them rather than expecting them to become mental health experts.

And lastly I think we need to focus on who is going to and how we are going to pay for these prevention initiatives. For me neither the renovate or the rebuild model adequately addresses the issue around prevention. So ultimately for us the draft report is an excellent starting place but it's not the finishing place. It makes several very important recommendations which we support, and I can go into, but the focus of this inquiry is on the personal social and economical impacts of improving the way we address mental health in Australia and mental health is not just the absence of mental illness, it's far more than that therefore we fully support the Commissioner's views that improving our mental health care or how our mental health care system is structured and functions is central to achieving this but we also believe there would be considerable benefit in focusing some resources, more resources, upstream to promote mental wellbeing and prevent mental health conditions from arising in the first place. To focus on the mental health care system supports the 20 per cent of Australians living with a mental health condition to also focus on promotion prevention allows us to cover 100 per cent of Australians. That's what we do in other areas of health and that's what we will need to do with mental health as well. Thank you.

PROF KING: Thank you. If I can just start off, you mentioned childhood trauma, child maltreatment, and completely agree with you on its importance and the significance and we've made recommendations around perinatal childhood health checks so I guess my question is, and clearly you think there's something missing there, what practical on the ground recommendations then do you want us to make to government so we're heading towards May next year and there's, you know, a couple of recommendations but it's got to be saying, 'The government needs to do the following, it has to be implemented'. Well, what would you want us to do?

DR CARBONE: Yes, so taking up the point about the importance of recognising and managing perinatal mental health conditions, so absolutely agree with that. But I think it's a little bit, as my colleagues from Beyond Blue had said, it's not just about screening it's what

you do then and I think you need to think about whether parents, particularly expectant parents or new parents, should be a group that requires fast tracked quick access, you know, to mental health services particularly if they have a diagnosed mental health condition, substance misuse condition or some other, you know, vulnerability in their lives which would perhaps impact on their parenting and they need to be given the most support that we possibly can; practical, financial, emotional and clinical and psychosocial supports, so I think it's beyond screening and into what other services are we recommending, you know, that parents, expectant parents and new parents, have access to but there's also research to suggest that you can use the time, you know, the antenatal period to prevent conditions like depression.

There are CBT-based interventions, for example, that could become part of antenatal classes or parenting programs. They could also simultaneously be helped to avert depression before it arises in that antenatal period so I think it's really just broadening the recommendation to look at, you know, 'Okay, here we have a population in a particular setting of antenatal services; how do we maximise that engagement that we have to both focus on prevention and early intervention because they're a critical group?', you know, parents throughout the life - you know, obviously parents with older children and adolescents et cetera but at that crucial first three years of life, first 1000 days, make sure you maximise your supports and services.

In regard to social and emotional wellbeing screening, again I think it's the same thing. What are you going to screen for and how as my colleagues from Beyond Blue said. If I think you're screening for disorders that might not be the right approach. Perhaps what you should screen for is the risk and protective factors and, for example, some colleagues from Royal Children's Hospital, Murdoch Children's Research Centre, which suggest you need to screen for is exposure to ACEs so if you know that a child has been exposed to one of the several known adverse childhood experiences connected with mental health conditions in childhood adolescence and later in life, screen for those and then intervene to try to, you know, deal with whatever's happening in the background so you're better off dealing with the cause rather than the symptom or the condition that flows from that because then that will, you know, basically help to short circuit the condition anyway. So that's an example of how you can build on that recommendation to make something a little bit more specific.

I mean on that, and just as an aside, the Federal Government announced after the Royal Commission into child sex abuse, institutional child sex abuse, that they were going to establish a centre for the prevention of child sex abuse. That's a great initiative but there's capacity to broaden its scope to look at all forms of child abuse and neglect. There's also capacity for broaden it beyond child maltreatment into childhood adverse experiences, childhood trauma, of one form or another so I think you need to think beyond the small and particular to the bigger and generic sort of underlying categories of things that contribute to poor mental health.

MS ABRAMSON: Thank you and, Dr Carbone, thanks for coming today to present. I don't know if you're intending to present a submission to us but we'd be really interested with a comprehensive list of the evidence-based prevention approaches that you think actually we should have a look at. And the second point to that is a funding issue. We've gone to some trouble in the report to think about, 'Well, what should be funded on a national basis by the national government and what should we fund on a State base?' but we're very open to what you've said about prevention but we need you to put some breadcrumbs down for us so that

we can say, 'Okay, well we need to look at these other areas as well' and happy for you to take that on notice.

DR CARBONE: Yes, and we will be making a submission so, yes, happy to include a list of those.

MS ABRAMSON: Thank you.

PROF KING: And thank you for going through that and I think for us part of it what should be delivered universally for all families, for the whole of Australia, and then identifying the higher risk groups that might have an aggregation of those risk factors that you've mentioned and targeting some interventions in that area so some of the interventions therefore could be part of what the original commission authorities that we've recommended take on because it's a local targeted intervention versus universal national perhaps run for the whole of Australia not specifically at local levels through the RCAs. Any comments that you might have in the submission about which area is the best way to get that intervention out would be valuable as well.

DR CARBONE: Yes, look, I think it's a complex area, I mean, as you know the more universal the intervention the smaller the effect size but the bigger the population that experiences the benefit and therefore at a population level it certainly is value for money but clearly, you know, the more that you can then define (indistinct words) groups that might be at particularly high risk the more likely therefore that they're going to have a better experience or more benefit but they're a smaller group but it's that tension between as you know, you know, getting the whole of the population to the left side, the mental wellbeing side of the continuum versus, you know, more targeted approaches. I think the problem that, you know, you often get with targeted approaches is determining who to target, you know, it's not always easy and that then leads to also potentially the issues of stigma.

You know, if you're selected out for some sort of special treatment, you know, they're, you know, - and this part of the problem with current approaches to parenting programs for, you know, vulnerable families because the uptake of, you know, highly evidence-based interventions like PPP, you know, is low because they're too stigmatised, you know, and you need to make those sort of programs more acceptable than normal and more people will access them because it's not like people won't benefit from them, it's just that some people will particularly benefit from them so I think we can make some comments about that.

PROF WHITEFORD: Thank you very much.

DR CARBONE: Thank you.

PROF KING: And our next present is Mouradian, I hope I've pronounced that correctly.

MR MOURADIAN: Mouradian, yes, is my name.

PROF KING: Please if you can come down and just state your name, if you are representing an organisation then please state that.

MR MOURADIAN: I wish I was (indistinct words) I'm just by myself, isolated.

PROF KING: All right so just please state your name for the record and any opening comments you'd like to make.

MR MOURADIAN: Yes, my name is Vikein Mouradian and I'm presenting as an individual and I believe that presenting as an individual gives the Commissioner or the Productivity Commission a different perspective than what we've heard from the organisations that have spoken although, you know, very eloquently and very genuinely so I appreciate that but nevertheless I believe I can offer a bit of a different perspective about mental illness and in particular I want to relate it to work.

Now, Clive Palmer said, 'Jobs, jobs, jobs and more jobs' so that's the point that I want to relate because you are the Productivity Commission and, you know, obviously the more people working, the more the government gets money as a taxpayer. And some would argue that it's also beneficial for the worker, although I would say probably not, if you have any mental health issues.

My personal experience in the matter has sort of shown that not only if you have mental issues, but if you're perceived to have mental issues, what happens to you is, you get the police sent after you; you get locked-up in a mental institution, then you get the police sent again, even though you've been released from the mental institution by the employer.

In another instance, you go to court, you get fined \$800 and given a criminal record by the employer, even though you've left the job; you get told by your union that, "They're not going to help you because they believe you're mentally ill." That's the union where I worked. And another one is your own organisation, the Australian Public Service Commission; you get told by the delegate of the Australian Public Service Commission, "We will never employ him," even though the AAT member - that's the Administrative Tribunal - member says, "Well, can you review the matter in about six months?"

The doctor or the Commonwealth Medical Officer and the Public Service Commissioner, or the delegate; he says, "We will never employ him." So, there presto, you don't work. So what happens is, the government loses, if you're talking about monetary sort of angle, from the monetary perspective. And as the Productivity Commission, I'm sure that's one of your tasks, to get the productivity going.

And in fact today, we even have the Treasurer Josh Frydenberg talking about this very issue of working. He claims, you know, there's been a 20 per cent increase in people 65 and over - and I'm 65, not over - so that's what the government is talking about, and they're talking right, in my view. They want to put people in work, because they're concerned, probably not so much about your mental health because they're concerned all this taxpayer revenue.

So I don't think they're really concerned so much about your mental health, but they are very concerned about getting the budget right. And of course, you've got to get the budget right, to get people working; the more people work, the better society we have. That's one of the key fundamentals of being in a society, especially in Australia where, you know, people work

very hard. So I actually want to get good mental health; obviously, you know, work is the basic foundation: if you're building a building, that's what you need.

So that's my perspective. I've had a lot of trouble because I can't say many things, it would attract defamation action.

PROF KING: Yes, thank you.

MR MOURADIAN: So I'll refrain from saying. But I gave you what happened to me; that was three jobs, three things. And one job in a hospital claimed I'd been threatening the staff; I'd never been near the staff, never even been near - he wanted to protect some woman. I've never been into that woman, I had no interest in that woman; I haven't had anything close to it, I haven't even tried to contact her.

The second one, at the Tramways, that was dealt with very harshly, after working 19 and a half years as a tram conductor; a very, very difficult job. You get three death threats, punch-ups, spat on, all kinds of things happening. You're working 24/7 hours of the week, getting up 4 o'clock in the morning. I didn't get up properly this morning, even though I thought I'd come early, still got out of bed at 7.

Then, the public service. I don't quite understand why the Australian Public Service Commission is so intent on you know, not taking anybody that they believe is perceived as mentally ill. As one of the speakers said, I think it was Beyond Blue, low intensity, it's low intensity. Now, there is no employer in Australia will employ anybody with low intensity mental illness, or perceived mental illness, and there is a lot of work to be done.

So my point is how society interacts with you, if you - you don't have to be mentally ill, that's the point. You know, you could be, you might not be, because you know, some people - you might look at somebody and you might think they're mentally ill; they might not be. You might look at somebody and your point of view might say, "Well, he's quite normal," but he might be more mentally ill than the other person. So it's a matter of perception, of how you look at it.

What I was going to say is, so why this insistence? I mean, the AAT delegate - this was a long way ago, a long time ago, but it does demonstrate as the problems you meet, because like I say, jobs, jobs, jobs; that's what Clive Palmer said, that's what we want, that's what's essential. And more jobs, he said, he said, "Jobs, jobs, jobs, and more jobs." Now, he's a bit of a flash sort of spin doctor, but that is you know, it's not that I not only agree with him, but that is the fundamental fulcrum of society.

PROF KING: Can I ask you, just on - - -

MR MOURADIAN: I want to finish off.

PROF KING: No, keep - - -

MR MOURADIAN: No, you go ahead, yes.

PROF KING: Yes.

MR MOURADIAN: I'm not a very good listener, sorry. My apologies.

PROF KING: Just with something like the Tramways Board; so it's a dual - - -

MR MOURADIAN: Used to be the Trams Board, used to be the Metropolitan Transit Authority.

PROF KING: Yes, so it's a job which has significant stress, as you said; it's early morning starts, you're getting abused by customers, there's - - -

MR MOURADIAN: Death threats, yes, the three of them.

PROF KING: Yes. Do you have any thoughts about the support that would be needed in those sort of jobs; what was missing when you needed support, when you needed briefing, whatever it is, in that sort of job? What was missing?

MR MOURADIAN: Well, the tramways is not a job you choose; it's a job that chooses you. It's not a job that people go in and say, "Oh, I want to be on the trams," nobody does that. Its people go there because they want to work and they can't find anything else, or they can't do anything else; it's a combination of factors. So it's more or less a compulsory job; you're really being pushed into doing this, if you want to work. You want to be unemployed on, you know, \$200 a week, well, that's fine. You know, most people like to have a bit more money than that.

So you could get more money, but it's not - what I mean is, when I worked there - I don't know now; they claim that the drivers of trams are getting \$90,000. Now, that's now when I worked there; when I worked there it was long hours and low pay, it could be characterised as too. And the reason for the low pay was because they said they would give security of employment; and as it happened, you didn't get security of employment because you just wasted your time because they sacked the whole lot.

The tramway terrain is very complex; it has a lot of migrants there, all right? It's a big migrant workforce. And it has two unions; now, I don't know whether it's still there: there's one union representing the clerical staff, and there's another union representing the tramways staff, or the platform staff, whatever they call it. So the two unions are in conflict with each other.

The other union, the union representing the tramways staff is getting much better pay and much better conditions, while the union representing the trammies, or the platform staff, is on low pay and has very bad conditions, very long shift-work. And it has very bad managers, not only inexperienced managers, but very racist; you know, you would think somebody that employed so many migrants would give some cultural training, because it is difficult to deal with a lot of different nationalities, I concede that.

You know, I find it difficult myself, you know, with the high rate of migration here in Australia; I have difficulty - no, not necessarily difficulty - I have a certain adjustment effort

to do, to deal with all these people, with all these different nationalities. I mean, I go to the shop, I meet a Chinese, then an Indian, so I have to sort of culturally adjust in a single day. Now, it is very difficult, and the tramway management puts somebody there that's - I mean, he calls me in and he makes out that I can't speak English, and he talks to me in broken English; now, if that's not racism, I don't know what is. I mean, that's definitely racist.

And my late mother goes there, gives him back my uniform because I didn't want to go back to the depot, and he does the same; he talks to my mother as if she didn't speak English, because she was a migrant. But as a matter of fact, my mother spoke real good English because where she came from, she worked for the Royal Navy during the wartime, so she spoke really good English. So that was so prejudicial.

And his clerks, these clerks, I meet somebody, a clerk, one of these clerks in the street, and he makes out that I'm mentally ill, "Oh yeah," he starts mocking me. And this is when I left the Tramways, I met him down in William Street. And they're always carrying on, the attitude, the whole attitude towards the mentally ill, or perceived to be mentally ill. Because, like, the Tramways has all types of people, like, it's a variety of people; you can go from top to bottom. Most are okay, the platform staff, they're pretty reasonable, they all work hard, whatever you might think of them.

But these people, they have a very sort of this approach of the employer, of his clerks, of his administrative officers, who are supposed to show leadership and they're sort of having a go at people who are perceived to be mentally ill, you know? And it's a big organisation the Tramways, and it provides a very essential service, and yet you know, it's failing its duty of care to the employees. You know, it's a complex organisation, not because - I mean, running the trams is not all that complex - but it's complex in terms of their employees.

Because you know, this is getting a bit racist here to myself, but I mean, there is all these cultural factors, and this is a big issue, you know? If the Commission wants to look at the cultural factors, because a lot of workplaces now you've got all different nationalities, and that takes a lot of - it's a different style of management you've got to adopt. And it's something that maybe you know, the Commission wants to look into.

PROF KING: Yes, that's good.

MR MOURADIAN: Yes, I don't want to talk too much, but you know, they are important issues, I think.

PROF KING: Okay. Just the one final question: so you were involuntarily detained?

MR MOURADIAN: I was at the Royal Park Hospital, yes.

PROF KING: Yes.

MR MOURADIAN: But it was released and he sent the police again to get me, in the afternoon. I was released.

PROF KING: Yes.

MR MOURADIAN: This is not a joke. I don't want to be in there, I don't want to be an involuntary psychiatric patient; I don't think anybody does. Anybody that tells you is lying. I don't like being in there. I was legally and lawfully released, so why is he sending the police again in the afternoon, to have me - this is a type of - this is what happens to you if you're mentally ill: people seek revenge.

I mean, if you want the psychoanalytic explanation of it, I think it's because, you know, this is only a hypothesis, but it is a valid point because when you see somebody that's different than you, right, and you see that in yourself, you want to fight it; you want to say, "Oh, I'm not like that." But really, we all have - as human beings, we all have the same symptoms to a degree, as somebody as you might see, call him a raving lunatic. So you fight it, you're seeking revenge, you're saying, "No, I'm not like that. I don't want television and see people," you know, "talking to me." You say, "I don't do that."

So if you see somebody saying, "Oh yeah, I do," you know, "I'm sort of mentally ill, I do see people talking to me, 'Oh look that guy is talking to me,'" you say, "I don't do that." So get the fella that's saying that, as a matter of securing my own self, as a matter of saying, you know, "I can't be doing that. I can't be saying," you know, "Obviously, the fella is nuts, because he's saying to me that, 'The people are talking to me on the television.'" So there's this seeking of revenge.

And hopefully, these inquiries and things like that are going to improve this urge of citizens of the state of Victoria or whatever, whatever they are, to seek that greater understanding of mental illness, to seek that sort of revenge that they want to get. Because this guy in the psychiatric hospital, he was just seeking revenge, it's all he's doing; he's not treating me, he's not doing anything. He's just get me locked-up, I haven't done a thing, I haven't been near that woman.

MS ABRAMSON: Could I ask you a question about the involuntary - - -

MR MOURADIAN: Yes, I don't want to go there.

MS ABRAMSON: No, absolutely not. All I wanted to ask - - -

MR MOURADIAN: No, I mean I don't want to go back there.

MS ABRAMSON: What I wanted to ask you is, we've got a very strong view that people need to have representation as part of that process; did you have any legal advocacy, or an advocate that looked after your interests, or you were just subject to the process?

MR MOURADIAN: Well, this happened in the 1980s and there was no process then. The process was really discretionary; it's basically based on the doctor, so it was very discretionary. But now we have the Mental Health Review Board, we have other things. But my personal view is that the discretionary procedure that they had before is better than the Mental Health Review Board, because that institutionalised you. They say, "Well, you can't leave because the Mental Health Review Board said."

But the other way, always discretionary, it was totally discretionary. There was no Mental Health Review Board, there's no rights, there's nothing; it's just up to the doctor, so you had to sort of beg to the doctor to let you go. So the discretionary way was better, because you can see the injustice. But if you're saying the Mental Health Review Board, well, that's an official body; they say, "Oh no, it's like a court," you know? You've been, that's it, the Review Board said.

In fact, it's very hard to get out of a community treatment order; in fact, the community treatment order you're really on it for life, much more than if you go to jail, because with jail you got to set a minimum you do, well, you get out of it. But you won't be getting out of the community treatment order, and it's controlling you in the community; it's like what they say, judging the community, which is pretty hard stuff, you know? You've got to go to a case worker every few weeks and take your tablets, and they inject it, so it's better not to be mentally ill.

MS ABRAMSON: No. What we're thinking in that regard though - and we've got some evidence around this - if you had the ability to have an advocate appear with you or for you - it doesn't have to be a legal advocate - there is evidence that people were less likely to be involuntarily sent for treatment. So that's why we've been focusing on that area.

MR MOURADIAN: Well, he would be more in the public eye; I mean, the doctor would be more in the public eye. So that puts him more - you know, makes him more publicly accountable. If you really wanted to press the issue with doctors in the mental health field especially, they've got to be made more publicly accountable; I mean, they're a very powerful group. And they're more powerful than the police, really. And you know the police are so powerful, that when you compare the power that they've got, they're even more powerful, so they're a very powerful group.

So we've got to be more publicly accountable; that's a very hard road to sort of get, because the doctors will resist that. They won't cop that, because they like to, you know, keep their power, so if you take away a bit of their power, even an inch, I don't think they will - if anybody can do that, you know, that would be great, if any organisation or government can do that: make them more publicly accountable.

I mean, you know, the judges and magistrates - I don't know about magistrates - but judges, every single case this week on criminal matters, they've given their reasons, you know? It's in the daylight, the sun. But with the doctors, it's underneath the table.

MS ABRAMSON: No, no. Look, thank you for coming to give us your evidence.

MR MOURADIAN: Yes, no worries.

MS ABRAMSON: Because I know that those are not easy things to do, and we really value hearing from you.

PROF WHITEFORD: Yes, thank you very much.

MR MOURADIAN: Yes, no worries. Thanks for your encouragement and all the great people that are in the room too; they've been helpful.

MS ABRAMSON: Thank you.

PROF KING: We'll just take a 20-minute break? Yes, I'm getting nods there. So let's take a 20-minute break for morning tea, and then reconvene; so see you in 20 minutes. Thank you.

SHORT ADJOURNMENT

RESUMED

PROF KING: Let's recommence, and can I invite Maggie Toko to come down the front? And if you could, for the transcript, state your name, the organisation that you're representing, and if you have any introductory comments you'd like to make.

MS TOKO: So good morning. My name is Maggie Toko; my iwi is Natubatah and Napuri, and I am from Aotearoa. I am the CEO of VMIAC, which is the Victorian Mental Illness Awareness Council. My opening comments are, I wish to talk about the value and importance of consumer participation in service design now, and into the future; and the importance of co-design in service management and delivery.

VMIAC is a peak mental health consumer organisation in Victoria, and we are an organisation that is consumer-based; both staff and the committee of management have a lived experience with mental health. We have recently formed an alliance with five other consumer peaks, representing Western Australia, New South Wales, South Australia, the ACT and Tasmania, to form the National Consumer Alliance.

I welcome the Productivity Commission recognition of the importance of consumer and carer engagement. On this occasion, I will reference my statement to consumers. The principle too is to build a mental health system that is truly person-led. I recognise that the draft report has the intention to place consumers at the centre of their care; there are references to psychosocial support and social determinants of health, but I feel these are without true understanding of what it means at the coalface, for the consumer on the ground.

Psychosocial support is someone who can walk your journey of recovery with you, as the consumer; to support changes as you change. Psychosocial support is not a quick fix. It is about a relationship building, relationship modelling, it is about identifying and developing skills you already have as an individual, as a partner, as a couple, as a family. Psychosocial support assists with your recovery journey. Again, your journey is not a quick fix. Journeys of recovery can be a lifetime thing. Having a mental illness should not be a lifetime sentence. Having a mental illness doesn't mean that you are unable to be productive, that you are unable to contribute to society. It just means that you contribute in a different way.

Consumers want to have a say in what happens in their lives. They want to be able to ask questions about their care. A system that has consumers at the forefront of care is a good system. As a society we should want to grow the foundations by having consumers participate in service design. It should not be just about what I can receive but what I can put in. The term 'recovery' needs to be defined so that when decisions have been made by the COAG health council they have an established view of what it means for the consumer. A system that is person-led will prioritise the importance of co-design and service management and delivery. A peer-led workforce that is enabled to develop skills and qualifications and match other streams will be important to the future of those workers who have lived experience.

A commitment by state and territories to acknowledge the lived experience workforce as a viable addition will generate a commitment to the value of co-design. I believe that we as consumers have the ability to participate in all levels of the development of services, not only as the users of services, but as core contributors by management and staff personnel, not as a stand-alone stream that is a collaboration of services and workforce. To influence the future, we need to be part of it. The issue of stigma features here due to a belief that having life experience lessens your ability to function on an everyday level.

VMIAC is living proof that you can have lived experience and function on a high level. I acknowledge that this is not the case for all consumers, but it is not because of who they are but more to do with the social determinants that influence their available choices. Peer-led services currently exist in countries like Aotearoa, England and Canada, to name a few. They are models which we should be encouraged by. That's the end of my submission.

PROF KING: Thank you. Would you like to start or will I?

PROF WHITEFORD: You're fine.

PROF KING: Okay. Your comments really related to consumer involvement, peer involvement in both design - all aspects of design and delivery of the services, and you said that you would like to see commitment to recognise peer involvement at state and federal levels. Hopefully we captured some of that in our recommendations. For example, when we see commissioning bodies that they should have peer representation or consumer representation on their board, at board level, so at a high level in those organisations, and that was our attempt to come up with a practical way of making sure that consumers are involved in that design. Do you have any other practical on the ground suggestions as to where we need to embed consumers, peers, in the system; make sure that that voice is always heard at every level?

MS TOKO: I think some of the practical things, I'd have them at the beginning. I have a younger sister who lives in Aotearoa and works for a politician there and she had the job of escorting Jacinda around Hamilton when she had her discussion about the Henry Bennett Unit, and we talked about Jacinda talked about having consumers right from the get-go, from the first stone that was laid right to the creation of the new unit, and I think she hits the target. She hits the mark, which is at the first foundations that are laid you have consumers there, then you're starting - it's not the - what is it the carrot for the donkey thing?

MS ABRAMSON: The cart before the horse.

MS TOKO: Cart before the horse, that's right. So you're not starting that way because that way consumers have to fit into that system. But if you actually walk side by side, and it is a lot like that recovery journey. The recovery journey is about taking it at your pace and I understand with economics that the pace is often a lot faster than it otherwise should be, but it's actually at a pace that grows with the recovery, and I think that it can be fashioned into something that is equitable for everybody, and an example of that is that - if I tell a little bit about my own story is that I recently had a health scare - well, the last three years have been a health scare because I've been treated by Peter Mac, and Peter Mac wouldn't think to do a single thing without me being part of it, without me saying what I want to happen, with me saying - without my partner saying what she would like to happen, without my friends saying what they would like to happen, and everybody is involved, and sometimes I think in the system that we currently have everybody is separated.

They're in their own little cohort, and no wonder there's no togetherness, and I was talking on the break with Gus and we were talking about New Zealand and some of the - you know, because there are a few steps ahead and what they do in mental health, and I wondered because it's a whole of - there it's a whole of government understanding, and I wondered if that was because of the culture that underlies the country, the Pacific Island Maori culture, that it's quite embedded in society, whereas I really feel for the indigenous people of Australia because they're quite separate to what's happening, and perhaps if their culture was embedded the same way that it is in Aotearoa, then systems that develop would develop with that culture, that kinship feeling and those types of things. Does that make sense?

PROF KING: Yes, yes.

MS ABRAMSON: Absolutely. I wanted to ask you - thank you for taking the time to come today too. I wanted to ask you about stigma. So we've heard a lot of evidence around this from whether it's with young children and people seeking treatment because they don't want their child to have, inverted commas, the stigma of mental ill health. We've thought from the point of view of national campaigns around it, but we're really interested in practical recommendations, especially based on your international experience, of what we can do to change the public conversation.

MS TOKO: Well, I think - I heard of a campaign where they just say, 'Who's your neighbour?' not what stigma is, not identifying stigma as such but, 'Who's your neighbour?' And I know I'm working with Blueberry and Tandem Carers looking at a campaign around, 'Who's your family?'. Not, 'Your family is your mother, your father, your sister, your brother,' but 'Who's your family?' It is who you say your family is, and I think that's the kind of campaign that should happen with stigma. Just, 'Who's your neighbour?' People don't know who their neighbours are. People don't have a sense of community. There are individual communities scattered around, but you want a whole response from a huge community, from the country, really, around stigma. Stigma - I think campaigns that deal quite clearly with developing community are a good way to go.

MS ABRAMSON: Yes.

MS TOKO: I think campaigns that talk about stigma - I prefer and VMIAC prefers to talk about discrimination because discrimination is against the law. Stigma, you can say you're looking at stigma, but if you discriminate against somebody it's against the law and people listen to that. But you don't want a society that's brought up with, you know, overly law-abiding-centric. You want a society that wants to embrace, and maybe it's about embracing your neighbour.

MS ABRAMSON: Can I ask, based on that, about community participation because we know that social participation and we've outlined it in our report, is incredibly important, but what type of practical recommendations can we make that would start us on the path that you're talking about?

MS TOKO: Well, VMIAC released a declaration two weeks ago and part of that declaration was how we would like to see the service system. In our ideal dream world, how would we like to see it? And we surveyed many consumers, who came up with different words for what they were wanting. For example, some were saying they didn't want psychiatry, others were saying they wanted psychiatry, but they wanted psychiatry just as much as they wanted yoga. The wanted psychiatry just as much as they wanted massages. Talking therapy. Those were things that people talked about. But in terms of consumer participation, it's really community participation. It's really owning who your neighbour is, owning who you are. I think owning who you are is a bit difficult because, you know, years of analysis. We're not going to get there, but owning who your neighbour is and what your neighbour does and what your neighbour sees and how your neighbour lives. It's actually a worthwhile thing.

One of the things - we recently had our conference and we had a youth conference at the beginning of the week, and I talked to young people, because I have 20 years' working with young people with mental illness, and I talked about one the things that we used to do in this youth serviced that I worked for was feed young people, and when you feed them, they're full, and when they're full there is no mischief that happens because there is only time to talk, and if you listen and you're available, then they will talk. It makes sense.

A lot of organisations and the department would say, 'What is it that you do there? You must do something because the violence rates are down and crime rates are down in that cohort of young people that you're working with,' and I said, 'I just feed them. Just provide a sense of community. I feed them and I feed their families.' They're just as hungry as their families. The families are just as hungry as them. It's not a big deal. It doesn't actually cost that much to cook a roast and to feed a group of young people, and I think that's what it is. I think people think that - and maybe the Productivity Commission is in that position where people think that you have to spend millions and millions of dollars. It's very practical.

MS ABRAMSON: We're keen on spending the taxpayer dollar quite wisely. But it's a really interesting conversation because we had a submission from the Library Association and it was a really interesting submission that I might not, to be honest, have thought of otherwise because they have become hubs for people, so that brings community in, and often for people who are quite socially disadvantaged, so it was those type of things, and I really listened to what you've said this morning, so it was those type of initiatives where we thought, 'Well, that's actually really interesting and it's not a high cost.'

MS TOKO: That's right, it's not a high cost. We run probably 15 forums a year at VMIAC, where consumers can come, where their families can come, and we have guest speakers and we have different campaigns that we're running and things like that, and one of the things that my staff do really well is they just listen. So my job when we run those forums is cook the barbecue, so I'm feeding again, so that's my job and then everybody else gets to listen to what the staff are saying and things like that. It's not that expensive to gather community together and that sense of wellbeing that is priceless. You cannot get that from - you can probably get that from joining a sports club, but for many consumers the price is out of their range.

MS ABRAMSON: Yes, I understand.

MS TOKO: But it is priceless when you bring them together and loneliness is a very big factor. I know having worked with young people, loneliness is one of the killers of young people, so they get housing, they get housing on their own and they can't survive because there's nobody else there with them, or they get put into shared housing that they don't get to choose who their housemate is and it breaks down, and again, it's a killer for young people and it is for aged as well.

MS ABRAMSON: I don't know whether you'll be putting a submission in, and we can just have comments. We've got a comments section. But some of the programs that you're running and that you're involved in that encourage social participation we'd be really interested in.

MS TOKO: We can certainly do that.

MS ABRAMSON: Thank you. That's really interesting.

PROF WHITEFORD: Thank you.

PROF KING: Thank you very much. Next is Charlotte Jones.

MS JONES: Can I just give you something?

PROF KING: Yes.

MS ABRAMSON: Yes, thanks very much.

PROF WHITEFORD: Thank you very much.

PROF KING: I will state just one thing. Obviously the transcript hasn't got the diagrams and so on, so if you can avoid sort of saying, 'If you look at diagram X,' and so on.

MS JONES: That will be fine.

PROF KING: If you could just state your name and organisation for the transcript and any introductory comments.

MS JONES: My name is Charlotte Louise Jones, I'm the general manager of the Mental

Health Legal Centre. We did place in our submission before the Productivity Commission explaining what we do. We've existed since 1987 representing people with a mental illness in detained environments across Victoria. The focus of our work is mainly inside prisons and locked wards, but in recent years we've branched into health justice partnerships. We've run two for the last four years, one's specifically on our advance statements and one specifically with the Bolton Clarke Homeless Persons team.

So I was particularly keen to discuss today the part of the submission where you said that you were lacking information in the evaluation of health justice.

MS ABRAMSON: Yes, we're very interested.

MS JONES: I'm very interested too. I'm very keen to talk about them. Our advance statements project has a very lengthy university document that was produced by RMIT that was fully evaluated for us by Dr Chris Maylea, who works that in conjunction with us. We also worked with VMIAC on that work as well to make sure that we had the strongest possible consumer voice on it, and it went into some very complex environments.

The documents I've given you today specifically relate to our health/justice partnership. What we aim to do at the Mental Health Legal Centre is we have an outcomes evaluation framework that sits across everything that we do, and that means that everything is evaluated on a continuous basis.

What's really important to us is that we know what our stakeholders are thinking, what our consumers are thinking and what our staff are thinking about what we're doing so we can actually drive a project forward. That's at the core of us. Does that help?

MS ABRAMSON: Yes. Just understanding a bit more about the health/justice partnership.

PROF KING: What exactly it does, yes.

MS ABRAMSON: What they are, how they function, and then I might, if you don't mind, come to some more specific questions that we want to ask you.

MS JONES: So health/justice partnerships are an alliance normally between legal centres or another service support and they can go across financial counselling and social work, along with an allied health professional group. We've found we work best with nursing teams and social work teams in the environments we've worked in. We tend to find there's a commensurate level of numbers and not the same pressure, so for the doctors and the psychiatrists it can be more complex. Yes, they'd love to engage, but they have a bigger problem, as it were, on the side. What the nurses and the social workers find is they're trying to solve some of these social problems, so the interplay works better. I've witnessed that across a number of the health/justice partnerships that we have operating in Victoria. I would specifically speak to the MABELS project that I know information is also available on, which is a mother and baby family violence project, and there is a large report that we can send you on that. I should be able to get a copy and forward that. That would not be a problem.

In regard to our health/justice partnership, it works with a group of nurses who work with

either the street homeless or those threatened with homelessness, which the vast majority of experience mental health problems.

What we did was we designed this project four years ago in conjunction with the nurses and their clients, and they have then led how it has worked. So everything about its development works on the basis of being fed into. It's not we go in and say, 'Hey, we've thought about a great idea.' It's about, 'What would you do if you had a lawyer? How would you make them work for you?' It's not about co-location. Ours works on the basis that our lawyer is actually in the office. One of the things we discovered that was really important in the early stages was that she had a mobile phone that they could ring. Over 144 of our contacts since the project began are just mobile phone queries saying, 'Is this a legal problem? Can we do something about this?' Or, 'What do I do with it?' That kind of consultation for health professionals has been immense and made a huge difference to their working day. It stops them puzzling over a problem. They just solve that. It took less than three minutes to make a phone call.

For the bigger legal issues they can actually calm a client down, so often what a nurse will find, in our experience, is that she'll go to see a client who'll say, 'I can't engage with my health problem. I have this other problem and it's far more serious and much bigger.' So the nurse will ring the lawyer, and they'll say, 'Really? You can just ring a lawyer?' and they answer the phone and she says, 'Yeah, that's what this whole scheme is designed to do,' and the client automatically engages with the lawyer.

It might be that that thing we can say is, 'Look, that's nothing to worry about. We can deal with that. It's not urgent. Nothing is going to happen today.' Or it might be, 'Yeah, it is urgent. The police are coming to arrest you. There is a batch of outstanding warrants. We'll go with you and we'll deal with it.'

The health/justice partnership has now prevented imprisonment of people, it's stopped the loss of homes, it's changed how people interact with their nursing teams and kept them in contact with them and we've also been able to measure health outcomes, so clients have now started to say to us, 'Yes, my health is better because I've had this service, and I can now engage in other services.' So we see it as a steppingstone for reintegration rather than a, 'We fixed this, now you fall off the ladder again.'

MS ABRAMSON: I have two questions. I'm really pleased you've come to give evidence today. The first one is how do people find you? Are you found through the medical model, for want of a better word, that we have nurses who say, 'Well, actually, we can connect you with a service,' or do the police connect clients with you? How does it happen?

MS JONES: In terms of the Bolton Clarke health/justice partnership, if you are either a Bolton Clarke nurse or the Bolton Clarke nurse is co-located in any of the services, they all know about us.

MS ABRAMSON: Yes.

MS JONES: We only have one lawyer who has dealt with 420 cases since this started, so she is rather busy. We would like to see a few more lawyers because we think there's the

demand, but it's proved that it can work and it can be effective, and that was the starting point of it. In terms of the advance statements, that was done across every platform. We put it in specific community mental health services, we put it into secure psychiatric services and we also just put out a general call, so now anybody can show up at our office on a Friday afternoon and have an advance statement written. We just sit there and it's done with social workers as well as lawyers. So we're trying to have an interplay where you don't just have to see one person.

MS ABRAMSON: So the advance statement; are you talking about how a person says, 'This is the type of care that I want if I become unwell.'?

MS JONES: Yes. Yes, but we tend to have a much wider input than that. I've talked to, actually, interestingly, a lot of police about them, and they're really interested in seeing them get used and be made available to them so that when they came to be at a premises they could say, 'Oh, we understand you don't like being called Ted. You like to be called Teddy.'

MS ABRAMSON: Yes.

MS JONES: And this is what's going on, or these are the things that you might be scared of, and to understand some of the back story. We don't see an advance statement as purely the legal document. We actually see it as a journey and how somebody engages with services, so that people don't make those mis-steps that automatically make people go, 'I don't want to talk to you. Please leave me alone. I'm really scared.'

MS ABRAMSON: Ms Jones, we've very interested in this because it also backs onto an area where carers said to us for legal reasons hospitals and medical professionals wouldn't share information, and it seems to me that an advance statement that you're talking about could also provide some of those consents so that people could have information shared with their families or carers.

MS JONES: Yes, and they can be signed - because they're a legally signed document, all of those things can be attached, like the nominated persons.

MS ABRAMSON: Yes.

MS JONES: The other environment I've seen them used in a lot and heard of them being used a lot is in aged care to give a picture of the individual possibly before they became unwell so that people understand things better. The story that I heard that I thought was fascinating was somebody who used to be a fireman, so every time somebody rang a bell for lunch, he would become incredibly distressed, and they figured that out and stopped ringing the bell. It's the really simple things that matter to people, but they're really easy to convey.

But they are quite nuanced. They need to be written very succinctly. I have had a couple of advance statements that went for 50 pages. It's a little hard to expect a medical professional or anybody else to sit and read that before they deal with somebody.

MS ABRAMSON: Can I ask, how are you funded?

MS JONES: Largely we're funded philanthropically. We have just received some money from the state government to support us with our work on the Royal Commission but, yes, the majority of our funding is philanthropic.

MS ABRAMSON: So your lawyers, if they need to represent somebody, they'd need to apply the usual channels for Legal Aid to do so?

MS JONES: Legal Aid generally doesn't cover most of our clients.

MS ABRAMSON: Because?

MS JONES: They fall outside the scope.

MS ABRAMSON: Because?

MS JONES: The infringement is not serious enough - - -

MS ABRAMSON: Although it can send them to gaol, presumably.

MS JONES: Even so, it's not quite serious enough. Often they will be told they might be able to see a duty lawyer on the day.

MS ABRAMSON: Yes.

MS JONES: Generally when our clients tend to show up what will happen is they're told, 'You fall into the too-hard basket and we can't see you today.'

MS ABRAMSON: Can I ask a couple of related questions? Mental health tribunals? Do you appear for clients before those tribunals?

MS JONES: We do. We managed to get to 200 this year. Again, it's an unfunded part of our work, but we do it with the support of the pro bono community across Victoria. We're very heavily supported by a group of law firms who come in and deliver that with us, so we just have a roster. We send out all the hearings we have on the books and we see who can pick them up.

MS ABRAMSON: We're very interested in some statistical measures, and you do have that bias, I could see from your work, because we have been told anecdotally that when people have representation before a mental health tribunal it's vastly different to them getting compulsory treatment, so something like 70 per cent of people represented are not sent for compulsory treatment, so anything that you could assist us on that front, we really would welcome that.

MS JONES: Yes, we can certainly send you some of our data on that. We did an analysis of the impacts of having a lawyer some time ago and we were able to pull down that treatment orders were dramatically reduced from the request to what was agreed, was dramatically lessened and the impact, yes, of having a lawyer present. I think our stats came out at about 82 per cent, was the difference in a treatment order being made or not.

MS ABRAMSON: No, well, we're very supportive of this so the data would be great. One final thing, and you will have gathered I'm a lawyer so I'm pressing you on all these issues. Prisons. So we had a recommendation in prisons that really went to standards of care because we thought, 'What can we practically do?' We're looking for really practical things in that space. Well, if we had people working on the basis that they would develop standards of care, so the standard of care in the community would be what the standard of care for your mental health treatment in prisons should be.

MS JONES: Yes.

MS ABRAMSON: So that's something practical we thought of because we're looking across Australia and different systems have different arrangements, whether it's corrections or it's Department of Justice. So we're really interested if you've got some ideas about what would make a difference for treatment for mental health conditions in prison.

MS JONES: The first thing is that the PBS must follow you into prison. For us that is an imperative. Most people are not. Certainly in Victoria Justice Health takes over, which means that carefully titrated medication falls off at that point. It may well have been given in the community, it may well be somebody is medicated. It disintegrates - - -

MS ABRAMSON: But that's about the medications. We heard from the pharmacy - - -

MS JONES: Yes, so it's really quite daunting how many people have their medication removed the second they go into prison. Unless you can provide the evidence of what they were on prior to admission, it then takes quite some time to then get them back on medication. Your Methadone program doesn't follow you into prison, which is, again, incredibly serious. A lot of people have been self-medicating for a long time using a variety of substances, and alongside that there are very differing levels of care across every prison, and it can be really hard to work out where you would target, but for us I think if we could increase the number of forensic beds, I think, across the system so we could actually treat people with mental illness and maybe pull them out of being in prisons and stop them becoming the new asylums and maybe turn them back into what they once were, that might be useful.

I think the other thing that we see the most of is the fact that you're discharged with no medication. I don't know how many people have experience of what it's like to be discharged from a prison, but you have the natural housing problem that the rest of the community is facing. You're trying to sort out your Centrelink, you're trying to sort out where you're going to go, how you're going to eat, and somebody has given you a prescription for medication and you have no money. You are set up to fail the second you walk out. So unless we can sort out the in and the out parts, and particularly for those discharged from court directly into the community, because we forget the vast majority are discharged not from the prison but directly from court. They don't even go back into the prison. The prison has got no way to pick them up, so it's how we think about the system, and I think that's a much bigger system overhaul as to how we provide that care, because it's got to have some kind of continuity to it.

MS ABRAMSON: As you know, we're looking through the mental health lens, but we

would really welcome a submission from your organisation and pointing us in the direction of some areas where you think we should have a look at program et cetera.

MS JONES: I'd be very happy to share all of our inside access programs as well that operate in Dame Phyllis Frost and Ravenhall prisons and the work we're doing in there.

PROF KING: Harvey, did you have any questions?

PROF WHITEFORD: My question was about the relationship with Legal Aid and how you interface different, but you've explained that.

PROF KING: Can I just ask one final one on the advance statement? So from another inquiry dealing with end of life and advanced care directives, which obviously are clinical statements, but one of the issues that we found was simply they were ignored, clinicians didn't even realised they existed until it was too late, so even though these were meant to centre the care around what the consumer wanted - - -

MS JONES: Yes.

PROF KING: - - - in practice it didn't happen, and so I'd be very interested in your advance statement. Do you find that's a problem?

MS JONES: How do you make it work?

PROF KING: Have you solved that problem?

MS JONES: What we did when we launched the advance statements project was we did a joint education system, so as we went in and delivered them we educated all of the practitioners we were working with, and you have to keep that really current. The same applies to the nurses. You can't launch a service and just go, 'Okay, well, we'll just run it and it will just keep delivering.' We have a 96 per cent uptake with the nurses. The reason that we have such a high uptake is because we go in every two months and they know the team. They can ring and talk to any of us.

We did the same when we launched advance statements. The reason we will have a presence in Thomas Embling Hospital, the reason that we still have a presence down at Saltwater Clinic is because we worked with the teams that are there, so it's that embedded tri-focus across the consumer, the team, how we evaluate and how we communicate. You can't write an advance statement in isolation.

PROF KING: Yes.

MS JONES: You have to have those conversations with your client, and you have to encourage your client to talk to the team. But what's lovely is when the team get the client to come to you as the lawyer and the don't see you as a threat. That to me is the perfect symbiosis, and the advance statement is put with all the legal paperwork for mental health tribunal hearings in the file, which means it's easier to find, as a general rule, I think, than the advance care directives are, which I think tend to get buried in the file, not put in the legal

section, which is more common in a mental health file.

MS ABRAMSON: Ms Jones, we would like to have another discussion with you and I've asked the staff if they could talk to you about that. Thank you very much.

PROF KING: Thank you very much for that.

MS JONES: Thank you very much for your time.

PROF KING: Next, if I could ask Dr John Bellavance to come down. Dr Bellavance, if you could state your name, organisational affiliation for the transcript and any opening comments you'd like to make.

DR BELLAVANCE: Okay. My name is Dr John Bellavance. I have a PhD in values education from the Faculty of Education at Monash University. My expertise is in the moral use of information and communication technology by young people, and the impact of ICTs or technologies on their wellbeing. I'm the founder of cybervalues.org and I've been writing and teaching values education for 30 years.

I teach ICT in a Melbourne high school and I'm also the Australian vice president of the Universal Peace Federation, which is an NGO in general consultative status with the Economic and Social Council of the United Nations.

So thank you for having me today, and what I would like to argue today is that without values education in younger children or in childhood productivity and wellbeing in schools and in the workplace will always fall short. Hence, the social economic benefits of values education is what I'm going to argue.

As a high school teacher of 19 years, I've come to understand the challenges that students face with respect to their personal development and their social engagement with others, challenges associated with their own attitudes on their own antisocial behaviours. Helping young people meet these challenges is critical for their mental health and their ability to be successful in the workplace and in their relationships. I've come to know that many young people desperately need values education. Of course, the primary source of values are parents and the extended family. However, as a teacher, I've seen first-hand a lack of values in our students. This is shown in a lack of respect towards their teachers and others. It is shown in the lack of control with respect to their behaviours at school and their lack of accountability with respect to their own inappropriate behaviours, the lack of self-control with respect to their uses of ICT and the lack of managing themselves in their personal sense of responsibility with respect to their own learning.

In this situation we have today, parents will often side with their children, even if the child does not take responsibility and sometimes blame the teachers for the failings of their children. But on the other hand, parents also increasingly expect schools to foster values. The outcome of this is that our children lack a sense of responsibility for their own actions and their outcomes, they often feel entitled to what they have, entitled for what they want and a lack of resilience when life does not go the way they want.

These problems are now manifested in the workplace and many examples of issues of resilience in the workplace. This is where the social and economic benefits of values education stand out. After all, all employers want individuals with a strong sense of responsibility that are reliable, resilient and have emotional intelligence. But where and when are these values and these abilities fostered? How can they be fostered is the crucial question.

The second outcome of lack of values education is the struggle that young people encounter when they're confronted with their own personal limitations as young adults. They struggle with little to fall back on when it comes to values and that allow people to be resilient. This then leads to mental health and relationship issues.

So why do we need values education, personal development and relationships education; there is five reasons.

First there is a need for a proactive to deal with mental issues and low self-esteem with a lack of values meaning in purpose in the lives of many people.

Second is the need to foster a moral identity of the individual as a good and successful person. Third is the need to address the deficiency in private and public values. Four is the challenge faced by families and fifth is a need to empower individuals. I will talk to you today about the first two points.

As we know in Australia one in five people experience anxiety, depression, substance abuse; one in four young people are at risk of mental illness and so on. Some psychologists maintain that one third of patients who seek help from mental health professionals present with the issue of lack of meaning in their lives rather than chronic anxiety or depression. We need a proactive mental health education; namely values, personal development, relationship developments, since it clearly points to the importance of values, purpose, human responsibility and human relationships all of which provide meaning and wellbeing.

So the question finding meaning is very important to mental health and it's very important for resilience. One of the key elements of mental wellbeing is the right mindset; viewing oneself empowered to be responsible for one's own destiny and to become self-actualised. This requires fostering values, self-reflection, self-regulation, critical evaluation of one's behaviours. A self-actualised person knows their values and their purpose.

Another aspect of mental health is understanding that happiness cannot be pursued. It is ensued from how we live our lives. I teach this to my students all the time. Nobody owes you anything, life does not owe you happiness. Happiness is as a result of your actions, the actualisation of a potential meaning and purpose in our lives. One must have a reason to be happy and once found one becomes happy.

The fundamental issue of being human is the need to find purpose and meaning in our lives to be self-actualised. This is critical for mental health. Most of our time and energy is spent on developing our careers and making money, although these are necessary this can lead to the pursuit of happiness that is external often ignoring the internal values and abilities that allow us to develop ourselves individually in our relationship.

For many this self-focused and external pursuit of happiness can be unfulfilling. Also many people often search for the meaning and happiness and pleasure fulfilling immediate gratification yet now allowing them to find meaning and happiness. I argue and some psychologists argue that such widespread phenomena as depression, aggression, addiction, are not understandable unless we recognise the vacuum of meaning in the lives of people. So therefore another proactive mental health education as we all know is this fostering self-esteem but what is self-esteem? How do I feel good about myself? I feel good about myself the way I live my life.

Self-esteem is an important aspect of personal wellbeing and happiness. Low self-esteem is one factor associated with depression. Self-esteem also ensues from how we live our lives based on the values and purposes we actualise. Young people are encouraged to develop in Australia many identities; sports identities, performing arts, academic identities, but we need to also foster a moral identity which means that being a good person is an important part of my value.

I will conclude my remarks about the challenges that we face as a society with respect to values education. What is needed is knowledge of the values and abilities that allow individuals to be good and to be happy. Schools tried to do this from various degrees but often have limited our time allocated to pursue this. Additionally, teachers and parents often lack the training and values education so I conclude that mental health relies in part on a holistic approach so I suggest that we need a holistic approach in Australia that a broad - you know, a holistic framework for values education and over the last 20 years I've seen as governments change, one that the flavours and the changes in this which actually does not promote consistency so it's either not included or it's changed and so on so we need to have a bit of a longer view of how this can be done and it can be done.

(Indistinct words) doesn't matter which governments come in, if a framework is broad enough and clear enough it can be done. The values and abilities that underpin, for example, more and effective practices allow young people to face the challenges they face. I raised four sons and it doesn't mean they didn't have their struggles, we all have our struggles. If we're honest each of us faced many challenges in life but how we cope with them depends very much on who we are and what our values are and we need an understanding of the values that also drive antisocial behaviour because that affects their mental health.

The young people that I see struggle with their antisocial behaviour, we seem them struggle with who they are and their identity later on and they will carry that in their workplace and we know this, we all know this because we all work in a workplace and we can judge very easily, you know, who has issues and who does not.

PROF KING: Can I ask - sorry.

MR BELLAVANCE: I'm almost done.

PROF KING: Please, (indistinct).

MR BELLAVANCE: So basically as a teacher I'll conclude I found several challenges. First is resources exist right now in the values education sphere that particular aspects of

values some person (indistinct words) relationships but there's not a comprehensive framework that exists at the moment that we can use. Second, schools try to address values and personal development the best they can but there is often little time left to seek to teach the content of an already crowded curriculum. And third, we need a consistent approach which I talked about a little bit earlier.

Such a holistic approach in conclusion relies basically on six pillars. The three that are probably found in every values education curriculum, the first three is that we need to manage ourselves well; our relationship with others well such as family, peer and community; and our relationship with our physical and natural environment well which includes our home, our neighbourhood and our natural world. These life goals rely on values and abilities associated with the next three pillars which is basically the three moral and psychological domains of reasoning, emotion and behaviour.

Within those six pillars it is possible to develop a framework that is holistic. I'm happy to assist the government implementing this and I will have a curriculum written within those six pillars by March 2020. Thanks for your attention. I'll take some questions.

PROF KING: Thank you for that. One of the things that we found in our consultations with value-based education, with value-based programs, with broader social and emotional wellbeing programs; two things that I'd like you to comment on. The first is the school principals found that they were overwhelmed with different programs, that they had many programs being put to them to teach resilience, to teach values for students, to teach wellbeing from all sorts of different perspectives so that the principals found themselves often just flooded with these programs, unable to decide, 'Well, which one's better than any other?'

The second is that talking to many people who had developed these programs, they all had good reasons why their program was better than everyone else's program but again the problem was they all came from slightly different perspectives and ended up creating quite a flooded and confused market so your perspectives on that, that you're developing a curriculum; why wouldn't a school principal see your curriculum and just go, 'Oh, just another one' and how should we actually think about helping the schools to determine which programs are needed?

MR BELLAVANCE: Yes, what you said I agree with you 100 per cent. Yes, it would be easily perceived just as another program so therefore I think what needs to be done is to take a broad approach to this. I'm not - in my framework I'm not going into immense detail but I think a holistic approach is needed and so therefore it would be easier for teachers, because teachers don't want to read an entire volume of why - you know, what are the characteristics of emotion - there is many different ways of approaching things and it becomes quite lengthy but they want to see a bigger, broader approach so you need a framework that's simple and broad enough and then they can tease that out themselves.

So without that kind of framework, and I would suggest that we need a values education summit in Australia. Get the best people together and get them to sit together, and it's going to be process - trust me, all these people do have very strong views because I've interacted with many of them - it's not going to be easy but just because it's not easy doesn't mean it's

not worthwhile. But I would suggest honestly to this Commission is we need a values education summit and it will have an impact on productivity for the next 20-30 years, I honestly believe that.

PROF KING: Okay, second point before I pass off to my colleagues, is there would be some schools who would say, 'But we have a values education' in particular, and I don't want to pick on particular school sectors, but of the private schools which educate a significant number of students many of them would say, 'Well, the underpinnings are the reason why we are a private school and my parents choose our school' is that we have a values-based education and values are viewed through our curriculum so I guess my question is twofold.

Firstly, are those institutions falling short in your view? Are they incorrect when they're saying they've got a values-based education? And if not, so if they do have that values-based education, we should be seeing systematic differences between the performance of students coming out of those schools than other schools and I'm not sure I've seen any of those to suggest that so those two questions.

MR BELLAVANCE: Yes. I guess whenever you teach values (indistinct words) you can't go wrong and if you ask me my opinion whether it's an independent school or religious school whatever you can't go wrong and the schools develop their frameworks and it's very, very critical. It has an impact, I've seen it. However, there's two challenges there. One is that teachers will often complain to, I'm the head of faculty, will complain - - -

PROF KING: Look, John. We have a crowded curriculum - - -

MR BELLAVANCE: - - - the fact you want us to do more now, they're supposed to do more. There's a lot of pressure put on schools, teachers particularly the ones that are in the cold front, you know, in the classroom so that challenge is that - I'm not quite sure how to address that now, it's a bigger discussion to be perfectly honest but that's one challenge.

And the other one is that we need to train teachers in that space and you might say, 'Well, yes, some schools do' and some of the schools probably do but it has to be consistently done and it has to be implemented well and I'll be honest with you, even the schools that I've seen that have very good values education curriculums still have challenges which means we're not there yet if I can say now it's a bigger discussion but I still feel honestly we can do better in that space.

MS ABRAMSON: Thank you. I'm interested in your comments around values because we've certainly seen, and this is not a personal view, it's just an observation, that the whole idea of values is very, very fraught in the public space in terms of public education. As Stephen said when parents may for an independent school they have a view says, 'This is how we teach' but every time we have a discussion about values in a public space it's a very difficult conversation so I'm just interested that you've probably been leading the way on this; how have you got to the position where there is 'an agreed set of values', it's very contestable?

MR BELLAVANCE: Yes, extremely so. The minute you say what values (indistinct words) my PhD that's the first question you have to address, 'Who's values?', it's a legitimate question. In the 1970s when values education was introduced it was basically let the kids

decide their values, it was a warm and fuzzy approach. To be quite honest I don't think it worked all that well. Certainly empowering young people, and I argue that in my PhD, to find their value and discuss them is critical but there is a society - we are a society, we're an extended family if you want, and there are certain values that we can stand for that are not dogmatic, not, you know, with agendas and so on, they're our universal values and, I mean, if you start with (indistinct words) declaration of human rights there are some very critical values they don't consider universal, it doesn't mean everybody agrees with them. No one's every going to agree on anything 100 per cent when it comes to values but the attempt of the discussion, the dialogue, and so on is still very critical. And there are universal values. If you want, I can give you a submission on what I think those are but I think that they're a - anyway, yes.

MS ABRAMSON: No, I'm more interested I guess in the public space. As I've said before when parents make an election about the education of their child in an independent school they've got a view the schools are quite express, 'This what we teach too' but there's so much public debate around 'the values' so your views on that in a public system would be interesting.

MR BELLAVANCE: Well, I taught in the public system and private system so I can tell you both and both of them try their best. Teachers are great teachers whether they're in the private or public. To be really perfectly honest the public sector - a private sector has an advantage because (indistinct words) resource but the challenges to values education are the same. Look, it's true; parents will pick a school I think because they look at the ethos of the school and think, 'My children will get a good set of values' and that's, you know, good on them, that's important to them. I'm not really sure if I understand your question but - - -

MS ABRAMSON: Well, I understand your link is that the teaching of values is a critical part of the social and emotional wellbeing of young people, I understand that, that's the link and my underlying proposition was when we have a public - and this is not view, I'm just putting it to you - when we have a public conversation about values it's a very difficult fraught, 'Who's values?' so that's all I was saying.

MR BELLAVANCE: The answer to that is that if you sit with a room of parents and you ask them, 'What values do you want our kids' - to be honest with you 89 per cent are shared. It's the same when we come in - we live in a multicultural society which is amazing in Australia, right, and in the UN Interfaith, I'll give you an example, is an important part of UN's work because religions go to war but when you really look at the fundamentals of religion actually some studies show that they have about 80 per cent shared values so, wow, if religions can agree on shared values then people who are not religious can also agree on shared values so I think it's a conversation that can be had and I think it's really noble. I don't see - you won't have agreement everywhere but you can expect that.

MS ABRAMSON: Okay, thank you.

MR BELLAVANCE: Yes, you're welcome.

PROF KING: Thanks very much.

MR BELLAVANCE: Thanks for the time, I think I went over my time, sorry.

PROF KING: No, no, no.

MS ABRAMSON: No, no, we're doing well.

PROF KING: Next people, Bridget Hogan and Dr Jennifer Bibb if you could come down front, thank you. And again if you're able to state your names, your organisation that you represent for the transcript and then make any opening statements that you'd like to make.

MS BIBB: My name is Dr Jennifer Bibb. I'm representing the Australian Music Therapy Association and I'm their mental health advisor.

MS HOGAN: My name is Bridgit Hogan and I'm the executive officer for the Australia Music Therapy Association or 'AMTA' and we're here representing AMTA today which is the peak industry body for the music therapy profession in Australia and Jen I will be doing, if it's okay, a joint opening statement.

PROF KING: Please.

MS HOGAN: There are over 600 registered music therapists with the Australian Music Therapy Association otherwise referred to as 'registered music therapists' or 'RMTs' and they work primarily in the disability aged care and mental health sectors but we also have RMTs who work in paediatrics, oncology, palliative care, neurorehabilitation, and they provide services in hospitals, community settings, residential care facilities and schools. Now, recognising that music therapy is one of the smaller and lesser known allied health professions and sometimes a little bit difficult to conceptualise.

I just thought I'd take a moment to talk a little bit about what a registered music therapist does. As mentioned music therapy is an allied health profession and AMTA is a member organisation of Allied Health Professions Australia. RMTs have advanced knowledge in contemporary psychological theories, research and aetiology and how music engagement activates neurological structures and human behaviour.

We use evidence-based and targeted music therapy techniques to influence behaviour, improve cognition and communication and develop emotional awareness and competence and some examples of some of the techniques that we use mother include structured or unstructured improvisation, song writing, lyric analysis, play list compilation, therapeutic singing techniques and music assisted counselling, active and receptive music engagement, to name a few. These complex music therapy techniques are underpinned by research as well as fundamental principles in traditional talking therapy like humanism, psychodynamic and psychotherapeutic practice and cognitive behavioural therapy.

Like our allied health colleagues both registered and self-regulated, music therapists registered with AMTA must complete a training course accredited by AMTA which currently is a two year's master's degree. They must adhere to AMTA's code of conduct and practice standards and they must participate in compulsory and rigorous professional development programs. AMTA also meets regulatory requirements aligned with the national alliance for

self-regulating health professions to which it has recently submitted an application to ensure its governance framework is equivalent to its registered allied health colleagues and to increase consumer confidence in the same and ethical practice of RMTs.

Today we would like to provide feedback for the Commission to further consider and hopefully include in its final recommendations around reorienting health services to consumers particularly with regard to MBS-related psychological therapy. If it included we believe our comments will enhance reforms for health care access that is more consumer driven, equitable and effective in meeting the needs of people living with a mental illness. I'd now like to hand over to Dr Bibb.

DR BIBB: Regarding the report's premise of creating a people orientated system. The report states that in order to make the mental health system more consumer driven and people oriented, governments should remove the barriers to accessing mental health care including addressing service gaps, lack of coordination and workforce shortages. Despite this acknowledgement of the importance of consumer driven treatment and addressing service gaps, there is no mention within the report of addressing the major gap that is limited access to diverse evidence-based treatment options within the current mental health system.

Traditional psychotherapeutic and psychopharmaceutic treatments are effective for many consumers but these traditional approaches fail to work for a number of people and for them there is substantial need for additional forms of treatment and therapy that can more effectively support them. For example, people who have been impacted by the trauma and challenges of mental illness throughout their lives often like the emotional vocabulary to participate in traditional talking therapies. In this case they may choose to engage in music therapy or other creative-based therapies that provide the non-textual language to gain emotional literacy.

Research shows that for some consumers such as these music therapy will dominate or be preferred over other psychological-based treatment options including those which are currently available within our mental health system. This means that if music therapy continues not to be funded (indistinct) the government is funding a lower value treatment which is a serious issue of inequity. Music therapy is an evidence-based therapy which has substantial support for its use in mental health treatment. Systematic and Cochrane reviews report significant effects of music therapy for people with mental illness in reducing the symptoms and improving quality of life for people with high and low prevalence mental illness and in increasing the outcomes of other therapies when used adjunct.

Despite these published and known benefits of music therapy there is still limited access available to these people most in need of music therapy through the existing mental health system. If the Commission truly were dedicated to creating a people oriented system that is holistic and comprehensive the proposed system would acknowledge the diversity in consumer needs and offer an expanded range of evidence-based treatment options.

Research by key scholars in the field of mental health shows that pathways to recovery are individual and diverse. Within a consumer driven model of care consumers should be entitled to choose treatment options that suit their individual needs. As included in the AMTA's submission to the Productivity Commission a recent benefit cost analysis conducted

by health economists concluded that if music therapy were to be included in government funded schemes that already offer therapy sessions provided by allied health professionals, there would be little to no cost to taxpayers in return for significant results for consumers who choose music therapy as their preferred treatment.

Given the strong evidence-base for music therapy to provide symptomatic relief for people living with mental illness, we recommend that the mental health fund music therapy provided by registered music therapists in order to fill an existing service gap and provide equitable access to a cost effective and often consumer preferred treatment option in particular in regards to the Stepped Care Model and the MBS funded Better Access scheme.

Currently RMTs work with people from the (indistinct) of mental health services, as articulated in the report, both people with mild and moderate symptoms who are receiving treatment by their GP and/or via the MBS and people requiring specialist treatment and hospitalisation. Consumers are already choosing to access music therapy as part of their treatment which reflects client need and advocacy on a local level for diverse approaches to recovery. However, the majority of these consumers who choose to access music therapy as part of their treatment pay for it out of pocket.

Many of the major hospitals in Australia do employ RMTs as part of their allied health treatment team. So people requiring hospitalisation can sometimes access music therapy for free during their inpatient stay however for people with mild to moderate symptoms and those in the missing middle they must pay out of pocket. This is a major concern since the majority of people accessing mental health services in Australia are from low socioeconomic backgrounds and are unable to afford to pay for private therapy.

We acknowledge and agree with the Commission's statements that a Better Access scheme should: be aimed primarily towards people with moderate to high intensity needs who stand to gain the most from face to face psychological therapy; should be rigorously evaluated to ensure it is delivering cost effective benefits to those who need it; and that it is currently inflexible. However, we argue that without expanding the range of professionals who can deliver (indistinct) psychological strategies to include other allied health professionals such as RMTs, the program cannot be cost effective when these therapies are often the preferred choice for consumers.

The program will remain inflexible if it continues to restrict the range of professionals who deliver psychological strategies to only OT, social work, psychology and nursing. This range does not reflect the number of allied health professionals qualified to provide evidence-based strategies and approaches that may be prioritised or needed by consumers. This exclusion creates an unnecessary barrier to accessing other evidence-based strategies like music therapy and it's not non-congruent with the Commission's approach to prioritise consumer needs and priorities in their recommendations to create a people oriented system.

Accordingly we request that an additional draft recommendation is added within part 2 stating: 'Changes should be made to the MBS rules to expand the range of professionals eligible to provide focused psychological strategies such as music therapy'. We'd be keen to discuss this further today but firstly we'd like to thank you again for giving us the opportunity to provide feedback and to contribute to this once in a generation opportunity to work

collaboratively towards achieving a lasting mental health system that supports Australia's most vulnerable people.

PROF KING: Okay, thank you.

DR BIBB: Thank you.

PROF KING: I'll start off really on that last point which is relating to not just the MBS funding but also how consumers become aware of the different therapies and music therapy is one of a number of evidence-based therapies, for example, there's upper mind and body-type therapies that have evidence-based behind them. Where do you see the gateway for consumers to receive these therapies because I can imagine a consumer goes to a GP, says, 'Look, I'm getting anxious' or 'I've got particular symptoms', the GP says, 'Ah, excellent. I'll refer you off in the right direction and maybe a mental health care plan' - we've got an information request out there on that - but should the GP then be saying, 'Oh, well here are your choices, your ten choices of different therapies' at that stage and if the answer is 'yes' how do we avoid the consumer just simply saying, 'Well, I don't know that's why I'm asking you' and so would GPs be the ones who are the guides for consumers or an alternative would be to say, 'Right, well you enter a Better Access scheme', for the want of giving its current name, and there's a dialogue that occurs with whichever professional is providing the face to face therapy under Better Access and that dialogue then leads to the decision by the consumer, 'Well, actually I'd like to use some of my sessions for music therapy' and again if so how do the incentives play out in that system where obviously you have a person who has, the clinician in that case, has an incentive to keep professions with them because any system is going to have some sort of cap on the number of sessions and that's just reality of government and taxpayer funding so I'd be very keen - even if the recommendation that you want, even if we put it in there, we then need to say how will this be implemented, I guess that's what I'm getting at. So my question to you is how would that be implemented on the ground to actually enable that consumer choice?

DR BIBB: Yes, absolutely, and we recognise that that is the next step and so we see it happening via referral from the GP and so, you know, also acknowledging that we'd need to provide education to GPs around what music therapy is and why a referral might be appropriate in different cases for consumers, you know, particularly for a consumer who's unable to kind of process things through traditional talking therapies we'd recommend a referral that way or if they were already engaging in music for mood regulation and anxiety management and things like that in terms of the training and where it would go from there we recognise that, you know, we'd need to provide some education for GPs at that level.

PROF KING: Do you think that education is enough? I mean, one of the comments that has put to us is that we are in a system under Medicare or ten minute medicine for GPs; do you think that the GP would be able to get enough information, and remembering we want the consumer evaluating the choice here, enough information in a ten minute session with a patient or the consumer to be able to give the consumer the right choices so the consumer can make the decision as to the referral pathway, that seems a lot to ten minutes.

MS HOGAN: Yes, and I think the responsibility falls on the profession to not only educate the GPs and the referral sources but also to consumer groups and the consumers and roll out

our own campaigns to raise awareness of music therapy just not to health care professionals but to consumers. I don't think that's one of a GP's greatest challenges with the amount of allied - not just allied health services but the many services that could be available for consumers to access is to know how to point them in the right direction and how to guide the consumer bearing in mind that the consumer really must be participating in that conversation so I think the onus falls on the profession, ourselves, in rolling out an education program for both consumers and for the referral sources. I'm not sure if that's what you were getting at.

PROF KING: Yes, I'd be interested further if you plan to put in a further submission I'd be very interested in getting more details around that because I still have trouble seeing how that would work under our current system and one of the issues that we're grappling with is, even if we think of some consumers coming in and face to face therapy or music therapy is appropriate for them, but for other consumers actually moderated online, group therapy, some of the other therapies mentioned earlier today, the GP is trying to do all of that within the timeframe; so make clinical judgements and then provide advice to the consumer we're having trouble at the moment seeing exactly how that would work with even a more limited range of options, once you start expanding the options it seems to start making - you risk actually having the situation where GPs say, 'Well, this is the easiest. Here's a referral, go off there' and we get worried about that because that takes away consumer choice.

DR BIBB: Yes, it does. But hopefully that's not the reason to restrict eligible therapies or eligible disciplines or professions because it's going to be too difficult for a GP to (indistinct words), yes we need to work on it, a system that can empower the GPs to have that knowledge or to access that knowledge and to communicate and share that with the consumer. Yes, that is one of the challenges.

PROF KING: Or as I said, you know, is there an alternative gateway? It may be that you have a 50 minute session with an allied health professional who can then, you know, (indistinct words) Better Access session who can then present the alternative pathways once they've got to know more about the consumer, but anyway rather than brainstorming here I'll pass over to my colleagues.

MS ABRAMSON: I just wanted to ask one question and bearing in mind time pressures I'm happy to have it on notice I'm hoping you'll put in a further submission, it's around working with young children and we heard yesterday from two professors about how very, very early in life mental illness can become diagnosable, for want of a better word, so I'm really interested in your submission fleshing out where music therapy works in that space because I've made an assumption actually that with kids who are not verbal that actually music therapy could be a very important part of therapy and also within schools because within the school model it's a different funding mechanism so just really interested and happy to take it on notice.

DR BIBB: Yes, so we can certainly provide some research and things regarding children who are non-verbal and the work that - because RMTs are working with children in that space in Australia. In terms of in schools and in terms of early intervention and prevention we have had some research where we've had some programs funded by the ARC for music therapists to go into schools and work with wellness kind of welfare counsellors and those kinds of people within the schools to provide education around healthy and unhealthy 'eaters

of music' which is a term that we use in music therapy to kind of describe how music can be both a really great tool for healthy coping and coping with emotions for young people but also acknowledging the negatives that using music can bring because we know that four young people who have trouble regulating their emotions and perhaps have a mental illness, we know through research that they often can use music in ways that's not helpful and that actually reinforces negative thinking patterns and behaviours that they're already engaging in.

So this program went into some schools with children at risk and used this kind of - their HUMS program to look at how we change the student's ways of using music so that they're more aware of the music that they're listening to, and how it can actually promote their mental health, rather than - and you know, be a resource for them going forward, in future. And that showed really positive results for the students.

MS ABRAMSON: And a formal evaluation.

MS HOGAN: Correct, yes.

MS ABRAMSON: We'd be very interested in seeing that.

DR BIBB: Yes, I can certainly pass on the references for that.

MS ABRAMSON: Yes, thank you very much.

PROF KING: Thank you.

PROF WHITEFORD: So I guess my comment would be similar. I don't know if you've seen what's called in the code, this IAR document, which is the primary healthcare network guidance document that the Commonwealth has produced? It's worth looking at because what it tries to do is give guidance to GPs about where on the stepped-care model, patients, clients who they see, can be referred; there is no mention of music therapy in the document, which I'm sure comes as a great shock to you.

But the challenge is, what the other commissioners have raised is, what information will be needed to guide that? There is over a million people - which you probably know - go through their access system, a lot of people. And most of them come through primary care and go through GPs, get a mental healthcare plan; and in that, the GP has to make a call about whether to prescribe medication, refer to a psychologist, social worker, occupational therapy or psychiatrist.

And if you could look at the document, just look at the domains which are proposed in the document, and just give some thought to what would have to be added to provide the sort of information in front of the GP which would assist in thinking more broadly about options that the consumer might choose.

MS HOGAN: Yes, and I'd link this to a conversation we had with the MBS taskforce when we submitted a very similar submission with regards to their mental health reference group; and a lot of the questions are, "Well, what is a trigger for music therapy?" And you know, a GP, "Well, when? Who would I refer to music therapy, and when would I refer to that?"

And that question can be asked of each step in the stepped care model, and we certainly need to - the education program needs to be very much about what are those triggers for music therapy for mild or complex illnesses? And the cohort that might be best suited to music therapy. But we would definitely also refer to that document.

PROF WHITEFORD: Which is on the Department of Health website.

DR BIBB: Yes, okay.

PROF KING: All right, thank you very much.

MS ABRAMSON: Thank you very much.

DR BIBB: All right, thank you.

PROF KING: Now, I think Debra Scott is the next person. Ms Scott, if you could just state your name and your representative body for the transcript, and then any opening comments you'd like to make.

MS SCOTT: Thank you. My name is Debra Scott and I am presenting myself, as an individual. I might mention here very quickly, it was actually a talk that I had with someone, so I've sort of come not fully prepared.

As an individual, where I will start, I was initially a carer of mental health services, short-lived, and I am now a user of mental health services. I am a user of mental health services in relation to a topic that's been touched on today: I became a survivor of loss by suicide. And the reason I am wanting to talk is picking up on listening here today - one thing that I found that these two topics, for me, they're interrelated - is the barrier of stigma that I felt was a double whammy.

And when I talk about this, I'm not going to disclose anything too personal about being a survivor, because I am still working through it. But what I found was I framed the nature of what occurred in my family behind a wall of the silence of stigma to protect myself, at a time when I didn't even have any mental health condition.

If I backtrack: as a carer, I had gone through it with a family member; it was the pre-2014 Act. I was studying - I'm a social worker - and I was studying mental health at the time and finishing my masters. I am fully aware of the changes in the 2014 Mental Health Act. And I recall a question was raised earlier around advocacy, and had I have had that when this adverse event occurred to me, I would've had more leeway.

But being a critical social worker - and I use the word "critical" - for me, there is a difference - I'm stepping into professional and then I'll move into personal. The critical social worker is one that works within a system for people who have marginalised voices, from oppressive things like I'm talking about: stigma, the shame of speaking out. I had a crisis situation where I was at a hospital, dealing with what was happening, and I said, "I don't need cards. I

need to have a support in place with you until I can work out what's happening here, in my family."

My social work role was, I am faced with going home, I have no community support, I have no family. My daughter at the time was living overseas, it was just me and the other family member. The reason I raise this is because if this had happened to me after the Mental Health Act, when I was in the hospital setting saying, "I can't do this. I need one night to sort this out. I need some support because I am dealing."

The other reason I raise it - and I think it's been touched today - I went to the Royal Mental Health Commission; a key thing I learned - because I've been researching since this happened to me, being a social worker and wanting to go back to study one day. A key thing to me is how - it's identified in the report - lived experience; it's very valuable because we can inform - I say "we"; to me it's a community, that's what I felt when I went to the forum. It was a safe space, I could disclose what I wanted to, with other people.

A key thing I took away from that setting, there was a variety of societal issues affecting people; could be eating disorders, sexual abuse. There was a range of issues, but we shared a common identity on the day. Many family members were prone to some sort of mental health themselves as a result of their family member. A key thing there for me was how we work with services to get the lived experience.

What is missing? Access to services, pathways when you've got a crisis. And I will move on from here. And I found in that setting, sharing our experiences of a system, knowing that the royal commission is listening to our voices and we're working together to solve an issue.

But for me, one of the key things - and I'd sort of like to really raise this - so prior to this, I am operating in a situation of societal/structural situation; the nature of my death is rare in the context of normal and abnormal deaths. So one, I have a rare - I learned this through my research. The second thing I learned was when I spoke to one person - I forgot to bring an equation: this person's death was also work-related, so I had a legal context, so I'm dealing with two additional layers.

Not only when later on - because my mental health didn't start initially then, it was sometime later - so not only was I dealing with a rare nature of death, something that is stigmatised - perhaps not by me, but by some societal views. The way I context that is historically, some people see it as selfish, some people see it as sinful, some see it as a crime; or perhaps, some people, it's not talked about.

Even today I'm quite anxious, and I'll share that, but I'm controlling myself. And that's what happens; it's not a conversation that you start up and say, "Oh, what happened?" That happened. Stark wall of silence and I think to myself, "Okay, I'm not going to mention that." So I create a secret environment. The thing that I was unprepared for when I went to a doctor, as I think I just recently then - when I initially went as a carer, there was a - the person could've got a mental health plan; I said, "We don't have time for a mental health plan. I am a social worker; we need to be linked into a service." "That will cost extra."

"I'm not worried about the money and the bigger question; this person has a crisis. We need to push the boundaries." That happened the next day: supports were put in place with work, so this person could go on; so supports were there. What I learned for myself - and I don't mean to be jumping, and I've got limited time - what I learned for myself was sometime later when I actually reached a crisis point; I decided that I had a choice: I could stay behind the silent wall of stigma; I could live in fear of speaking out.

Where I had learned to speak out was at support groups, people like myself. Because we were too scared to speak out to other people. Very valuable.

PROF WHITEFORD: Can I just ask a question?

MS SCOTT: Yes.

PROF WHITEFORD: Sorry to interrupt. So just what would've made a difference at the time for you; how could the system have been different to make it easier for you to speak out, and not feel behind that wall?

MS SCOTT: The system. If I can come to the workplace, perhaps? It would've been nice for the workplace - because I'm pre-2014 - it would've been nice for someone to say to me, "Wow, that's really tough, what you're dealing with." We don't have a lot of supports available at the moment.

PROF WHITEFORD: In the workplace?

MS SCOTT: In the workplace, or even at the GP; we don't have a lot of stuff available. But what would you need? In answer to your question, what would've been helpful? Empathy.

PROF WHITEFORD: From?

MS SCOTT: I hid it from my workplace because I needed to work until I could sort it out. The only empathy I got was from my university, because I thought, "If I'm a social worker and I can't use my experience when I'm ready to begin to make a - am I answering you?"

PROF WHITEFORD: Yes.

MS SCOTT: So I think it was having someone actually say to me, "The support I'm going to give you is a bit of flexibility. I'm going to cut you some slack at university. This is what you need to do." Is that making sense? So I had those supports in; it eased-off that pressure.

And I guess the thing I found is, given the context and the nature of the death, until my own research, grief and loss - societal structure tends people to just operate within that grief and loss theory, it doesn't have the additional layer, if I'm making sense? So people you're working with expect you to get well, "This is what grief and loss is, it's non-linear, but you need to be moving on." Am I making sense?

PROF WHITEFORD: I think the thing is, I know there are probably many areas, but if you had to just highlight a couple - you've just done one for us - through your experience, are

there areas where you could make recommendations that we could consider that would've made it different for you, made it better for you?

MS SCOTT: Okay. Even if I go back, there was an ED clinic; a recommendation could've been there. It was when I was talking to the mental health nurse, airing my opinions. If someone had have said, "We don't have a bed. This person doesn't meet the high-risk criteria," what would've been helpful then if someone had had said to me, "Do you have any other supports? Do not leave this person alone," rather than saying to me, "Oh, it's fine now. We've ticked-off the boxes, the person is fine."

PROF WHITEFORD: Yes.

MS SCOTT: Or even I guess, picking up on other people talking about information and knowledge; if I had have known what I know now, if that's making sense? If I had the education and the knowledge. So for example, at the doctor the next day, or even the ED: if someone had have explained to me what situational depression is, I could've Googled it and known not to leave that person; if someone had have explained to me, instead of giving me two cards and ring up. I wonder if I've answered your question? Key.

PROF WHITEFORD: So we've got only a couple - - -

MS SCOTT: Yes, I know.

PROF WHITEFORD: But if you had to give us one other one that would've made a difference for you, what would the next one be?

MS SCOTT: If there is a way that we can destigmatise I guess what it's like for us being left behind - I say us - and also, break down the walls of mental health, to break it down so if someone is breakable, reach out, because the cost of not reaching out is far greater than not.

And the final thing, if I am able to, picking up on the therapy; my daughter is a dancer and that's what we're wanting to do, is now use dance as a platform. But touching on the other people talking with art therapy; there is not much research out there, because we're looking at intervention. And that's where we're at, and we're hoping to use that because recent research over the last year and a half is showing that there is benefit in dance, music, art therapy. I went to a recent veterans' safe talk - because people can sometimes communicate through non-words. But it is only an additional resource. So thank you.

MS ABRAMSON: Thank you so much.

PROF WHITEFORD: Thank you very much.

PROF KING: Thank you very much, yes.

MS SCOTT: Any other questions?

MS ABRAMSON: No, no. Thank you.

PROF KING: Can you just see if there anyone else at this stage?

MS ABRAMSON: I think we really wanted one at a time.

PROF KING: In that case, I will adjourn for lunch. Yes, so if we recommence by 1.30; let's say that. So thank you.

LUNCHEON ADJOURNMENT

RESUMED

PROF KING: I'll reconvene after lunch the mental health hearings. I will actually grab back that bit of paper you gave me and then I gave back to you. Thank you. Just a reminder for anybody who's joined us at lunch time, these are the public hearings into our draft report, the Productivity Commission's draft report on the inquiry into improving mental health in Australia. The hearings are being streamed live via the Commission's YouTube site. All participants who have registered here at this hearing have confirmed their understanding that they may be visible or audible online. If anyone here has queries about this or does not wish to be visible or audible online please approach one of our inquiry team members here today or feel free to leave the hearing now.

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 asked participants to ensure their remarks are not 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 and use the visitors' room next to the disabled toilets. If at any time you feel distressed please approach one of our staff who will assist you. We also have with us Bronwyn Williams who is available to provide psychological support. You can tell we're into the fourth session of the two days when the Commissioner is starting to have trouble pronouncing names.

In the unlikely event of an emergency requiring evacuation of this building, the exits are located in the hallway between here and the lifts. Upon hearing the evacuation tone please leave the building and assemble at the grassed area across Bligh Street unless given an alternative assembly location by the fire wardens. Please put mobile phones on silent and if I could ask Dr Astha Tomar, please come down the front. Thank you.

DR TOMAR: Any chair?

PROF KING: Yes, any chair. And, Dr Tomar, if you could state your name and affiliation for the transcript and then if you have any opening comments you'd like to make.

DR TOMAR: Sounds good. So my name is Astha, Dr Astha Tomar, I'm representing the college - Royal Australian and New Zealand College of Psychiatrists the Victorian Branch. I'm the deputy chair of the Victorian Branch. And I have a little summary prepared if that's

okay I'll just go through it.

PROF KING: Yes.

DR TOMAR: Yes. So thank you to the Commissioners for giving me the opportunity to address you today and provide comments and feedback on the recently published Productivity Commission draft report.

Firstly, I would like to acknowledge the Wurundjeri people, the traditional owners on whose land we meet today and pay my respects to their Elders both past, present and emerging.

As I said my name is Astha Tomar, and I'm the deputy chair of the Victorian Branch of the Royal Australian and New Zealand College of Psychiatrists. The college is the principal organisation representing the medical speciality of psychiatry in Australia and New Zealand. It is responsible for training, educating and representing psychiatrists on policy issues. The college has more than 6600 members including more than 4900 qualified psychiatrists and over 1500 associate trainee members.

The Victorian branch of the college has around 1500 members including more than 1100 qualified psychiatrists and around 400 members who are training to qualify as psychiatrists. As mental health specialists psychiatrists are well positioned to provide constructive input into improving the delivery of the mental health services.

We see this inquiry as a once in a generation opportunity to critically evaluate and influence definitive reform of the mental health sector. This inquiry is a chance to increase focus on prevention and early intervention while ensuring a rehabilitative and recovery focus within the mental health services with the overall goal of increasing the cost effectiveness alongside improving the consumer outcomes.

In April 2019 the college made a submission to the Productivity Commission inquiry into mental health. The college's consultation process highlighted the realities of a complex, fragmented and under-funded mental health system which is failing to meet the needs of the most vulnerable members of our community.

The recommendations contained in our submission were based on extensive consultation with the college members from a range of faculties, sections and expert committees. It is clear that improving the mental health of Australians requires investment beyond the mental health sector to ensure all Australians have equal opportunity for good mental health regardless of their individual circumstances.

From the Victorian branch perspective we believe that the focus needs to be placed on the most chronic needs of the system and we argue that investment is needed right now to address under funding, under resourcing and undervaluing of Victoria's mental health system.

As part of this it is important that certain areas of need are addressed by the Productivity Commission, and we advocate for the government action around the following six key priorities: the first one being the governance, accountability and funding to establish a sustainable system. We at Victorian branch RANZP are supportive of the rebuild model as

mentioned in the draft report which aims at clarity and funding and responsibilities. Establishment of an authority like Regional Commissioning Authority, or RCAs, would help in providing continuity of services and minimising gaps in the service provisions.

In addition to that we would also like to highlight the need for mechanisms which need to be put in place to ensure that the funding which is allocated to mental health is spent on mental health. Mental health receives parity of funding with physical help. Funding is commensurate with current need and re-actable increased needs. Increased funding equates to improved consumer outcomes and the funding needs to be linked to the workforce strategies, and the (indistinct) of the psychiatrists and people with lived experiences are imbedded as leaders throughout the mental health services to ensure the structures and system create safe, high quality care for consumers and continuous improvement activities are undertaken.

The second key point is that there has to be an addressing of the psychiatry workforce shortage and improving the training pipeline. Now, amongst the OECD - Australia is below the OECD averages for psychiatrists per capita and the situation is forecast to worsen. We need more funding to increase the number of trainees and strategies to make psychiatry a more attractive option. We need to do better in retaining our public psychiatrists. The reason for psychiatrists leaving the public sector are multi-factorial, yet it can also simply be attributed to the excessive demands being placed on them in an under resourced sector.

We have to ensure that there are sufficient inpatient beds to meet the demand. The increased bed base has to be done so there are 50 beds available for 100,000 population. There should be a range of beds available including acute beds, sub-acute beds, intensive care beds and beds in secure extended care units. All major public acute psychiatry units in Victoria continually operate at 95 per cent capacity, which is well above the desirable levels of 80 to 85 per cent. These capacity constraints mean the psychiatrists currently have no choice as to which unit they admit the consumers to. Consumers of different ages, genders and symptoms are currently being admitted together which creates an unsafe environment for both consumers as well as staff. Appropriate gender and age specific wards need to be available at every service to ensure that the people are provided an appropriate option upon admission.

As mentioned in your draft there is a need for more dedicated child and adolescent mental health awareness. There's also been a mention of the missing middle, and that's our fourth point, that we have to establish out-patient centres for the mental health to address the missing middle.

We would recommend that the public outpatient clinics are re-established in Victoria to provide psychiatry treatment to the missing middle. These could access a mix of state and federal funding. These clinics could take a variety of forms from being imbedded in the hospital outpatients to integrated community mental health hubs which could include integrated drug and alcohol services, employment services, social welfare services, psychological supports and psychiatric services. We have also advocated for integrating the alcohol and other drug and mental health services to provide better continuity of care.

And the last point is increasing services to address the demographic changes. The ones that we have highlighted are the CALD, communities, that is the culturally and linguistically

diverse population, as well as the aged population, and increasingly aging population. As stated in Victoria's 10 year mental health plan services must address language and cultural values as these can hinder effective treatment and support, migrants of all status as a result from culturally and linguistically diverse backgrounds should be able to access culturally appropriate services in a language they can understand.

The Victorian branch advocates for the needs of culturally and linguistically diverse communities to be considered when the services are being established and areas of additional needs should receive a commensurate increase in funding. The number of Victorians aged 65 and over is said to treble by 2058. The aging population will result in increased demand for services for older people as well as with longstanding mental illnesses are joined by others with mental illnesses which develop for the first time later in life.

The Victorian branch has advocated to the Victorian Government for the development of a mental health plan for older people which takes into account the future demand and resources. It also identifies service delivery priorities. So those are the key priorities we wish to highlight in our submission I put today.

PROF KING: Thank you very much. I'll start at the other end. Hervey, would you like to - - -

PROF WHITEFORD: Thanks Stephen. So the issue of workforce, you've recommended increase in training positions.

DR TOMAR: Yes.

PROF WHITEFORD: Obviously for those training positions to be accredited by the college we need supervisors.

DR TOMAR: Definitely.

PROF WHITEFORD: Is there any recommendations that you might have or suggestions about how we can get more psychiatrists to provide that supervision which will accredit those - make those places able to be accredited as training places for the college?

DR TOMAR: I think for now the psychiatrists who are working in public hospitals where most of the trainees are working in your clinical work everybody sort of gets squashed in, so unless there is a time set aside for a psychiatrist to be able to provide supervision it's sort of becomes like it's on the go and it adds to that pressure, so one of the main things is that there has to be a recognition for the work - for the supervision work which is being provided by a consultant psychiatrist. There has to be recognition for it and there has to be a - you know, time set aside for it. It can be done but it can't be done when a psychiatrist is busy doing 20,000 other things which they are supposed to be doing.

PROF WHITEFORD: And so it's about having quarantine time for the supervision?

DR TOMAR: Yes.

PROF WHITEFORD: The second issue about training is that there are some concerns that we've heard about the training of psychiatrists including from trainees - - -

DR TOMAR: Definitely.

PROF WHITEFORD: - - -that a lot of the training is in acute public hospitals.

DR TOMAR: Yes.

PROF WHITEFORD: And a lot of psychiatry is as you were saying is not inpatient psychiatry and - - -

DR TOMAR: True.

PROF WHITEFORD: - - -so trainees become skilled perhaps at the sort of case mix that might be seen in an acute public hospital inpatient unit but receive less training in broader areas of mental health treatment.

DR TOMAR: Sure.

PROF WHITEFORD: Is there anything we can do to, if you accept that that's the case, is there anything we can do to help overcome that?

DR TOMAR: I think that would - there are two aspects to it: the first is the need for training and provision of the psychologically minded therapies, psychologically therapies in the public hospital. Now, the college has highlighted that there is a need for trainees when they've finished their training that they have to be more skilled in psycho-therapy but they don't really get that opportunity when they're training in a public hospital but that's mainly because if you look at the public hospital the services which are being provided they are acute in nature, so either they're being provided as crisis assessments and management plans in EDs or in the inpatient units.

So as far rotations go for a trainee they do end up having very limited trainee - limited rotation options, so unless the - you know, if and when there is a service provision for, apart from the acute services, the other services that are being provided, the trainees will have an opportunity to have training in those positions, but otherwise there has to be sub-specialities and super-specialty training positions which are quite scarce. For a trainee to finish their training they have to have a child adolescent rotation and it's next to impossible to get one in the first - you know, during your training, so as basic as something like child adolescent rotation is hard to get by, let alone a drug - you know, drug or alcohol or a psycho-therapy specific training position or a perinatal or an eating disorder. So, you know, we do come out - we finish the training and it's more, as you said, more acute service exposure than others, and we have highlighted the need for specific positions and the health services to provide those opportunities.

PROF WHITEFORD: Is it possible to look at where - like, offering training positions in the private sector for example?

DR TOMAR: Some hospitals do do that, some training programs do do that, but some hospitals, especially if they're not centrally located and they have anyway such a shortage of trainees it's not on the priority then because it becomes the trainees - they end up providing more - you know, the provision of the health service and their training, the focus of shifts when they're working in a hospital which is a pity but, yes, so there are some training programs which would offer those positions and then the trainees get attracted towards those programs but then semi-rural or regional areas are not able to provide that and they lose their trainees and they have a shortage of trainees. They have a shortage of psychiatrists, so it sort of feeds into each other.

PROF WHITEFORD: Thank you.

PROF KING: Couple of questions, you mentioned CALD services, culturally and linguistically - - -

DR TOMAR: Linguistically.

PROF KING: - - -diverse communities. And I think everyone recognises the need to have services that are, you know in relevant languages particularly if it involves therapy that are culturally sensitive. The question then comes up how they're actually done, how they're put in place, how do they work? Have you got any thoughts about that?

DR TOMAR: I think the first is just the recognition of the need for the same, and initial bit is the option of having an interpreter available and not using family members as interpreters, and also being aware of cultural aspects to a person's presentation as well as their acceptance of the treatment which is being provided. So one is the awareness which if we look at our training programs we do sort of focus a lot on it because initially it used to be a biocycle social model and now we're talking about it as a biocycle social cultural outlook towards whether it's the assessment and the management or the treatments being offered. But within a health service, within a psychiatric unit or the health service providing those options or awareness of that is still at the really (indistinct) stages. It's not there but it is an ever growing population group and the needs are quite different and they need to be acknowledged, recognised and catered for but I think the first step is just the recognition of it.

PROF KING: You said psychiatric training does include issues of relating to culture and diagnosis, so do you think that's adequate at the moment or is there more work that needs to be done?

DR TOMAR: Definitely.

PROF KING: I'm aware - as an outsider I'm aware that, you know, some presentations do depend on cultural background, that different cultural groups - - -

DR TOMAR: True.

PROF KING: - - -with the same underlying mental illness can present very differently.

DR TOMAR: Well, initially we need to be aware of it. Initially we are expected to read

about the articles and be able to sort of write up something on it, but when it comes down to hands on getting your hands dirty with an experience, it just happens along the way, so the opportunity only arises whilst you're working in a system, so, you know, the - when the curriculum is there, it's a part of the curriculum. When you're examined, it's a part of that examination process, but when it comes down to actually doing it, it's more what you learn along the way and the team you are with or the supervisor you are with, so it's sort of a lot depends on - it's almost like stroke of luck. Like, I the sense, getting an experience. If you had good experience as a part of a good supervisor, then you'd be more capable of doing - you know, handling those cases, but otherwise people are on a bit of a back foot around how to do those assessments and what to be aware of and what to offer.

PROF KING: So any suggestions about how to improve that, then? If you need to take that on notice - - -

DR TOMAR: Yes, I think for now what we are sort of suggesting, especially in Victorian government pre-budget submission we done the same thing, that we - that the funding to a service, there has to be a bit allocated - has to be set aside in an area which has more (indistinct) communities and then work on it.

PROF KING: Just the other area, and sort of again touches on the difference between the public psychiatrist's role and the private role. We've heard about the lack of or the shortage of public psychiatrists, but it's also been suggested that that is different to other medical specialisations because of the way private psychiatrists get remunerated but there's too little incentive for them to take on new patients but it's - I won't look towards Harvey, but it's much easier to operate as a private psychiatrist and much more lucrative than being in the public system, which we don't tend to see in other medical specialties or there are other offsetting positive benefits of being in the public system. So is there anything that we should be thinking about in terms of recommendations to the government in changing the way the private psychiatrists are remunerated in order to be able to help get around that shortage in the public systems?

DR TOMAR: I think the remuneration part is a bit to it, but I think more is the satisfaction you get as a professional in a private setting and I work in both, so I can sort of talk from a personal opinion as well as what we've been talking of the (indistinct). Where at a private level you do feel like you're achieving a lot more in terms of direct contact with the patient. You're able to do more of psychotherapy but in a public hospital your role just becomes like - it's more crisis-driven, so you're sort of just setting - you know, not setting fires. Putting out the fires.

PROF KING: Putting fire out, yes. Extinguishing fires.

DR TOMAR: Extinguishing the fires. Putting out the fires. In a public hospital, a doctor's role becomes quite limited. It becomes very narrow and I think that - and again, in a public setting the role is expected that of being a leader. But if you look at it, the role does become very much clinical oriented where you come and do your assessment and go away. So it just becomes very narrow and you feel quite undermined of what you can achieve, but you feel very limited with what is available there to be able to achieve that. So I think a lot of people end up in private mainly because the satisfaction of what you can achieve and what you can

push out is a lot more.

PROF KING: Yes.

DR TOMAR: So it's not just the remuneration. It's the kind of work, the quality of work you do, so you end up doing more of quantity of work and less of quality of work. So the expectation from the carer, from the family, from the community is that you have to provide that bio-cycle social cultural model. But the way you're remunerated or the hours you have, you would be having one session and you're supposed to look after whatever, 80 people on your board and you end up just doing a biological bit, so it's a pity but - so as a psychiatrist what you can offer doesn't happen in a public setting. It happens in a private setting.

PROF KING: Okay. Thank you very much.

DR TOMAR: Thank you.

PROF KING: Next, Steve Michelson. Again, if you wouldn't mind saying your name, the organisation and any initial comments that you'd like to make.

MR MICHELSON: Thanks very much, Commissioner. My name is Steve Michelson, I'm the spokesperson for Australians for Mental Health, and we really thank the Commission for allowing me to make a few remarks on behalf of AFMH today.

So just by way of background on Australians for Mental Health, we are a not for profit organisation that seeks to make mental health a national clinical priority so that together we can achieve once in a generation change on how we support 4 million Australians and their families who have been touched by mental ill health every year.

We like to think of ourselves as a people's movement guided by experts that is fighting to fix Australia's broken mental health system. We are proudly passionate about being a voice for those with a lived experience and working with the system and alongside the system and the sector to achieve improvements. We're governed by an independent board of directors that include experts and people with - and carer experiences including Sopana Bisim, John Brogden and Pat McGorry, and we also have patrons including Maggie Beer, Jessica Rowe and Allan Fels.

We are funded through a combination of philanthropic and crowd sourcing resources. We do not accept any money from governments of any political persuasion to ensure that we are able to help hold politicians to account, and we do believe that generations of politicians have failed Australians living with mental health issues over several generations.

So really what A for MH is about is to build a campaign that forces Australians to act, a little bit like the 'Every Australian Counts' campaign that led to the establishment of the NDIS and other social issues of late, including the way in which domestic violence was swept out from under the carpet.

We absolutely welcomed the draft report of the Productivity Commission and we hope that the myriad of failings that were found, but also the economic cost being between 43 billion

and 51 billion per year, provides an imperative for politicians to act once and for all.

In terms of further observations, we are not surprised by the finding of the draft report in relation to the scale of the problem and the fact that this has been underestimated by successive governments - territory, state and federal - for many years. We believe, therefore, and as stated, that successive governments of all political persuasions have failed Australians living with mental ill health.

Most OECD countries spend between 12 and 16 per cent of their health budget on mental health services. However, Australia spends only around 7 per cent, despite the burden of disease being around 14 per cent.

The economic cost of mental illness, as found by the Productivity Commission, we believe pales when compared to the human cost borne by those Australians routinely failed by the flawed system. We support the findings around the need to scale up prevention and early intervention services and the need to engage young people at the earliest possible time so as to prevent progression of illness and the development of high-risk and invariable costly crisis situations.

We also support the need for ongoing evidence-based psychological interventions and support for people who have attempted suicide or engaged in self-harm. The Commission's draft finding or draft report's finding revealing that 25 per cent of people who attempted suicide will try again, whereas only 50 per cent of people discharged following a suicide attempt receive follow up treatment is absolutely something that we say must change.

We also support the Productivity Commission's finding for the need for greater investment in services beyond health in order to tackle our mental health crisis. In particular, the needs of Australians with complex mental health conditions extend far beyond the clinical supports, and therefore we urge governments to consider investment in a range of areas including educational, vocational training, housing, physical wellbeing and other supports to ensure that a positive outcome is achieved.

In particular, on behalf of A for MH we speak on behalf of carers and families who are often forced to pick up the shortfall of the system which can negatively impact on their own mental wellbeing, careers and education opportunities.

It's our position that there is an overwhelming need for fundamental change to the way mental health services are delivered so that every Australian can access safe, therapeutic mental health care when they need it for as long as they need it, and therefore we support the draft report's finding around the need for reform in the following areas, being access to care and support, quality of care, improved prevention and early intervention services, clear pathways to care, improved support and services for families and carers, improved monitoring of physical health, improved and targeted specialist services and the need to end discrimination.

I just wanted to particularly highlight and support the draft report's observations around the missing middle, and in particular to applaud both the current coalition government but more recently Labor Opposition for endorsing on a bipartisan basis the establishment of the pilot

program to establish the adult mental health community hubs in the last budget to the tune of \$114.5 million, and in particular this investment was to support the establishment of eight trial mental health centres to deliver a range of free specialised mental health support services for adults requiring treatment, including treatment after hours, because our members, and in particular their families, like my own, have often found a system that's very complex, that's hard to engage with, and that obviously then has a number of negative impacts.

But as outlined in the last federal budgets, the adult mental health community centres will provide wall in coordinated care and advice for anyone with mental health concerns and will address what is seen by many as the missing gap in the mental health system.

The centres will be rolled out in eight yet-to-be-determined locations nationally, but ultimately, and per our advocacy to the federal government at the time, we would actually love to see one adult mental health community hub in each federal electorate across the country, being 151.

If implemented correctly, we believe that this pilot program may serve as a model for a future larger investment of public funds in critical mental health services. But in order to be successful, we believe that these centres must truly offer services that are unique but also that are combined, including service navigation support, specialist psychiatric care, psychological services, social and community support services, drug and alcohol counselling, 24/7 assertive outreach, consulting rooms, visiting specialists, facilities for GPs and allied health professionals and online and telephone hotline services.

We would also love for these services over time to consider other means of support around people with mental illness and their diets or alternative forms of treatment so that we move away from trends around over-medication.

So in conclusion, we thank again the Productivity Commission for its work and for the draft report, and we believe that it does underline the need for urgent action and structural reform that we will continue to demand of governments from all levels. We believe that the Productivity Commission inquiry is a unique opportunity to transform the way in which Australia cares for those members of our communities and their families who are touched by mental ill health, and we thank the Productivity Commission for this invitation to speak and attend the public hearing, and for the opportunity to present out case for change.

PROF KING: Thank you. Clearly the community centres is a key issue from your organisation's perspective, but perhaps moving forward, albeit slower than you would prefer. You also mentioned just in passing scaling up prevention and early intervention services. Particularly in that area, in the prevention and early intervention, or any other areas, what specific actions would you like us to recommend to government that we haven't covered off so far? So we recognise the community centres isn't something we've gone into detail with, but are there other areas where you say, 'Look, we think you should have recommended this. This is what we want the government to do.'?

MR MICHELSON: I think one thing that perhaps could be recommended that's not currently in there is the need to provide the inpatient units in early intervention mental health services but specifically for young people. So this goes to, I think, an observation that the

report makes around the way in which as a country and as a nation we have traditionally sought to treat mental health through the prism of the way in which we treat physical health, and so we believe that we're still really at the first base, if you like, in terms of actually providing enough beds and support for people with mental ill health, but given the prevalence of mental health issues amongst young people, we would love to see some of those inpatient units and early intervention supports budgeted for by governments, and so we think that a recommendation from the Commission would provide a great platform for that to happen.

MS ABRAMSON: All right. Thank you, Mr Michelson, for coming along today. I want to ask you about consumer and carer participation. We've heard a lot from other people who've made submissions to the inquiry, and also about the relational aspect of recovery. But one of the things that we're really interested in is that there seem to be different understandings of what the terminology is, so I'm really interested. What does consumer and carer participation look like from where you sit?

MR MICHELSON: We believe that consumer and carer participation really has to go to the implementation of what we hope is significant investment from government following inquiring, including that of the Productivity Commission, but also we know, say, here in Victoria there is the Royal Commission into Mental Health, which we hope will lead to some recommendations and, following that, investment. But it's not as if there hasn't been significant investment by governments over time. We say obviously and predictably that it's not enough. We would like it to be equal in fact to the way in which government invests to physical health, but we have to make sure that we don't throw good money after bad, and so we would strongly advocate, and to your question, that people with a lived experience, consumers of the system, people who care for those who are participating in the system, actually sit at the table and have a hand in the design of reform and to help decide how it is that, you know, future investment is made, and I think further to that we would say that, you know, often for our members it's about the coal face. It's about being in that time of crisis, you know, and having a resource that people can contact easily in order to seek the assistance and advice that they need instead of having to go through a long, convoluted process, often meeting dead ends.

And so therefore we don't want to see just an investment of several millions and millions and millions of dollars made without due consideration to what happens at the coal face and in real time in people's lives.

MS ABRAMSON: Thank you. We've made a number of recommendations sort of along those lines, about how people access services, navigation portals. We would really welcome a further submission from your organisation, bringing that practical focus that you've just talked about. Well, how would that actually work for people who are accessing the service. That would be really helpful.

MR MICHELSON: Well, thanks for the invitation and we'd absolutely love to do that.

MS ABRAMSON: Thank you.

MR MICHELSON: Thank you.

PROF KING: So thank you for what you've said. Coming back to the adult mental health hubs, one of the concerns that's been made to us is to ensure that there's no silos within a region receiving mental health services, that there's some planning for regional needs and that the services are all integrated. The relationship of, say, the hubs to other primary care providers run by the PHNs (indistinct) practises, et cetera. How do you see that working so that it not sort of silos within, you know, a regional area?

MR MICHELSON: I think it's a great question and I think it goes to the heart of how it is that we make these hubs successful, and I think also we would say that we need to be practical because, for example, if we do advocate, which we are, for there to be one adult mental health community hub in each federal electorate across the country, we know that certain federal electorates have better primary health services as it is versus others, particularly when we think about rural, remote and regional Australia, so I guess we would like to see as much interaction and collaboration between services as possible, but we appreciate that that's very much easier said than done and so for us we think - and perhaps leading to your colleague's earlier question, we think that as much local consultation as possible the better, because ultimately we are going to have to ensure that the hub fits into a local community and in fact capitalises on, you know, existing services, be they primary or secondary, where they exist, and that's also going to be really important to ensure that we extract the most benefit out of what is, you know, in the grand scheme of things, very modest funding, and to ensure that those trial sites are a success, so I'm not sure if that answers your question, but it's tricky.

PROF KING: Yes, it is tricky.

MR MICHELSON: Yes.

PROF KING: So a lot of the regional planning that goes on now is expected to be between the PHN and the state or territory local hospital network.

MR MICHELSON: Yes.

PROF KING: And we've heard that that depends a lot of personal relationships.

MR MICHELSON: Yes.

PROF KING: In some places it's working well and in some places it's not working so well. We've been I guess asked to give some attention to what we could put in place to sort of make that more likely to happen that isn't dependent upon personal relationships. One example is the regional commissioning area grouping of resources and pooling of money; that sort of thing, and the criticism of that or the concern about that is that you lose within that some of the specific service elements which have proved to be successful. So I guess anything you can - and obviously you can take it on notice, but anything that the organisation can provide us for how to get that balance right I think would guide us to being able to make the right recommendations.

MR MICHELSON: Well, thank you. I might take that on notice and actually provide you with some more information. I think, though, you know, from our perspective, and again

speaking on behalf of, you know, people with lived experience as much as possible as we can have a seat at the table, you know, is really what we ask for, and I appreciate not everyone can have a seat at the table. Of course not. We would love that, but it's not possible. But I think we will take that on notice, but as a general principle we would absolutely urge those localised structures to take on board the voices of people in the local areas with the lived experience.

PROF KING: Well, I think our view would be that every area planning mental health services that didn't have lived experience as part of it would be deficient from the outset, so I think that certainly would be our position.

MR MICHELSON: Thank you.

MS ABRAMSON: Could I ask one more question if I could, please, on stigma reduction?

MR MICHELSON: Yes.

MS ABRAMSON: And thinking specially about your own background in communications we'd be really interested in your views on that.

MR MICHELSON: Look, for Australians for Mental Health we think that the way in which we will truly see action and the way in which we will truly see mental health receive the investment in reform that it deserve is when politicians of all political persuasions understand that without acting they may suffer at the ballot box, and so really for use we believe that now is the time, as illustrated by this inquiry, but also by other historic inquiries like the Royal Commission into Mental Health. You know, we think that the time for mental health to become a national political priority has arrived. We think it's here, and that's absolutely what we are seeking to do and what we are seeking to support.

But the other big part to it is to ensure that decision-makers themselves also are educated and understand the lived experience of people with mental ill health because we know that in the halls of Parliament, whether they be territory, state or federal, across the country, there is still a reluctance and reticence for decision-makers to necessarily engage in this topic as fully as they might so, you know, for us we want to work with the media, we want to work with the institutions of society, both those within the mental health sector but also with corporate Australia, to try and break down those barriers and we absolutely support and love the observations and recommendations in the draft report that go to early intervention in schools. We think that's absolutely where this all starts, so we really do welcome that.

I think one other observation I'd make is that there is in Australians for Mental Health's eyes a need for us to differentiate between awareness campaigns and action, because we know that there are lots of organisations out there in the sector who do great work when it comes to awareness campaigns, and that's critical in providing support for people with lived experience, and we also know that government from time to time invests in awareness campaigns. But if we are truly going to, you know, break down the stigma, which is getting in the way of a lot of the reform that we would like to see, we do believe that we have to make sure that an awareness campaign, another awareness campaign, funded by government, is not seen to solve these problems. That, for us, would be selling ourselves incredibly short.

MS ABRAMSON: Thank you so much.

PROF KING: Thank you very much.

MR MICHELSON: Thank you.

PROF KING: Now, our next speaker is stuck in traffic. Normally I'd do this a bit later on, but is there anyone else from the floor who hasn't registered to provide evidence before the Commission today who would like to present evidence? If not, I will - then let's take a short break. Let's try for 2.30, hopefully, not 3.30.

MS ABRAMSON: Sorry, 2.30.

PROF KING: Let's just take a break for perhaps 12 minutes and hopefully the traffic will have eased up by then.

MS ABRAMSON: There's tea and coffee.

PROF KING: Outside. Thanks.

MS ABRAMSON: Thank you.

SHORT ADJOURNMENT

PROF KING: If you'd be able to state your name, the organisation you're representing for the transcript and then if you have any opening comments.

DR PRING: Yes, thank you. My name is Bill Pring and I'm the media spokesperson for the Independent Private Psychiatrists Group, and in my opening comments I'd just like to congratulate the Commission on what you've done so far with the draft report. Very comprehensive, covering a large number of very important points which we've identified.

We'd, though, like to be able to work with you further because we believe we've got quite a lot of good information to provide you for fine tuning the report that you'll finally produce, and I'd have to say we're certainly very inspired also by our patients that we treat. We work very closely with Jan McMahon of the National Network of Private Sector Mental Health Consumers and Carers and we work quite closely together, and I feel that our whole sector, both our consumers and carers, and the practitioner seems to be ignored somewhat in past inquiries that have occurred, so that I think it's quite important because our sector treats the seriously ill people in our community to a similar level as the public sector.

So we see about half of all the seriously ill people who are in our Australian community and therefore we think that's a pretty important sector not to ignore because we do recognise that it's important to look at the milder end of the spectrum where smaller amounts of input can achieve a lot of productivity gains in the workforce and so forth, but in the more serious end

of the spectrum, that's where suicide is more likely to occur, that's where there are bigger problems being able to work and so if you can treat people properly, that's the other thing that we feel is being ignored a little bit, not particularly by your Commission, but in other inquiries, but expert treatment needs to be provided to people in order for the social supports that are also vital for people to be useful and for people to recover and for suicide to be prevented.

I think that our sector has been ignored sometimes I think because even politicians have said, 'We treat the worried well,' meaning people that perhaps shouldn't be being treated and that we only treat the rich. But in fact we've done a lot of research on that over the last 15 to 20 years and we've got outcome measures, the HoNOS outcome measure, looking at the people that when we put them into hospital and they have a similar severity rating as people going into the public sector psychiatric hospitals, and so we think that the idea that we're just treating the worried well is quite wrong, and we have also done a survey that has shown that 45 per cent of the people we treat in the community are unemployed, and we know first hand there are people that will sacrifice an awful amount financially in order to be able to maintain private hospital insurance, for instance, and be able to achieve private care, and so they're not rich people. Twenty per cent on that survey of our patients are also receiving government pensions.

So we'd like to work with you to try and further enhance what is already an excellent start on looking at the productivity side of mental health.

PROF KING: Thank you. Just on the data issue that you mentioned there.

DR PRING: Yes, yes.

PROF KING: I'll look back towards where some of our people who deal with empirics are chatting to each other at the back. Do we have co-payment information for private psychiatrists? Sorry, it's just when you were talking I thought that was the answer and I thought, 'Ah, we actually do have a data gap understanding -' because obviously we have data about the number of billings and services and so on going through MBS but of course there's co-payment issues. You said that you'd done the survey where you'd looked at the severity level of a sample of patients of private psychiatrists, and you'd looked at you said 20 per cent of patients were receiving a government pension.

I mean, one of the issues that you would be well and truly aware of, and you said in your opening statement, 'Ah well, we're only treating the rich.' But of course data on the actual size of co-payments under the MBS, how they're spread, how many are bulk-billed versus non-bulk-billed; that sort of information is very hard to come by, and I was wondering does your organisation collect anything like that? Have you done surveys on anything like that that you'd be able to provide us?

DR PRING: Yes, no - - -

PROF KING: It's really filling a data gap from our perspective.

DR PRING: We're not highly funded, but I think that - I think actually the data on co-

payment is available under Medicare. I think actually it's like an averaged data, so it's looking across the whole lot. I guess that Medicare statisticians would be able to find the cohorts of people that may pay different gaps in data that's not publicly available, but I think that there is no doubt that there are significant gap payments being charged and we address that quite strongly in our main submission to you, and it actually applies across the board, really, with specialists other than GPs. Even the GPs I think we may find in the next find the gaps will increase, and it's not ideal because people - even some of my own patients where we do discount a lot of people. Maybe not back to the rebate, but back to the schedule fee, which is the government-approved fee, sometimes a little more, depending on people's circumstances.

If we didn't do that, if we didn't charge a co-payment we wouldn't be able to practise in a reasonable way and our - without going into a lot of detail now, our submission shows you how the fees that most of the psychiatrists as charging above the schedule fee now are quite reasonable if you look at CPI increases from the relative value study that was done in 1995, which was never formally completed but nevertheless there was a lot of data was known about what a fair fee for a doctor's service would be.

Then if you apply CPI increases which have not been applied in Medicare, you would find that the total fees that psychiatrists are charging are quite reasonable according to that sort of criterion, but unfortunately Medicare rebates haven't kept up, and I think that's actually going to be a rather big issue not just in mental health, but in a sense mental health consumers are like the canaries in the coal mine I think because they tend not - in the serious end of the spectrum, they tend not to be able to attract or be able to work consistently enough to obtain very high incomes, and so I think you may find that the mental health consumers are the first to be concerned more about the gap payments and the fact that - but I think all people across the spectrum soon will be complaining about gap payments.

PROF KING: And I think you are right; I think there is some data there because I can remember seeing it for one other clinical group. Thank you for your response there. Harvey, would you like to - - -

PROF WHITEFORD: The question came up earlier about training of psychiatrists, one of the issues that we've identified is there's the lack of psychiatrist numbers, especially some of the sub-special areas like child and adolescent and older age psychiatry, and the training that is heavily dependent on the public hospital system.

DR PRING: Yes.

PROF WHITEFORD: Is there any comment you could give us about how we could increase the number of training positions in the private sector?

DR PRING: I'm not quite sure - I can't, in a sense, speak for the whole sector and generally I have been involved in a lot of training over my time, just me personally and a number of people in our group as well. I think we've done most of that training voluntarily and still do, and I think that's quite a good system in a way, but if you were trying to get more training happening, you would probably have to put some funding into it, and I think that the - I'm actually, and our group is, a little concerned that with the high medical gaps and the emphasis

which is reasonable up to a certain point of having more consultation work from private psychiatrists means that we may be training even the modern psychiatrists out of the longer term care which we as a group feel is very important in terms of preventing suicide and allowing people to recover to the extent they possibly can.

Just as a - I'll de-identify, but there's a case of mine just recently who I saw this young man when he was 17 and he had his first episode of schizophrenia, and he has had one psychiatric hospitalisation since then. He's now the age of 45 and he has had one psychiatric hospitalisation to change him over to Clozapine electively, and that's the only psychiatric hospitalisation he's had. His GP was excellent and saw him initially, started treatment, I saw him. He's been able to continue working in his work at the time, which was in hospitality, up until the present time when a physical illness stopped him from working, and in private work we see a lot of cases like that, and it both inspires us and encourages us to get that story out into the community because that's what I think should be happening for all people in the community. Some sort of care like that. I see that person once a month and by doing so I've been able to prevent relapses and that sort of thing, and it's a very effective way of treating people.

PROF WHITEFORD: Thank you. The other question was about private health insurance and there's been some concerns raised about that. Did you have any issues on that that you specifically wanted to raise with us?

DR PRING: Yes, and again, they're addressed quite robustly in our original submission. We are very concerned about private health insurance. We're finding more and more difficulties with what we call unwritten rules that limit our ability to treat people adequately at times, and so we are concerned, and again, robustly, in our addressing of that, we feel that probably the private health insurance system is not sustainable really, I suspect, and we need to look at other systems which we've discussed this in our submission. We need to look at systems like medical savings account systems, like in Singapore, or whole of life insurance policies. Any change to the private health insurance system would have to be introduced over 25 years, over a generation probably, but it might be worth doing, just like setting up a superannuation system was a very good idea when that was set up.

May I also just say that it sounds like I'm talking just about private psychiatrists in the community, but in fact we do work with lots of other health professionals and mental health professionals in the community. I think that's not often recognised as well because we're not in institutional teams. We're not meeting twice a week. People think that there are no teams in the private sector in the community, but in fact we find who are good psychologists to work with, who are good GPs to work with, where we do not have to take the whole load of looking after the person adequately and therefore we don't have to see the patient as frequently and we can manage to see other people as well, and I don't think that system is actually recognised, and that's also discussed to some extent in our original submission, and I think that's a very important point; that we're not working on our own, and if we wanted to increase the number of the more serious cases that we can treat, then I believe we need a system that helps us all in the community work together even better and there's a suggestion in our paper, but I think it's eminently doable and it would be wonderful to see a system that actually more rapidly dealt with people in those circumstances.

PROF WHITEFORD: Yes, because what you're alluding to is what we've heard from other people who put submissions in, that the more you work with the more serious complex needs of consumers and patients, the more a multidisciplinary approach is essential.

DR PRING: Well, it varies, you see. I think that case that I presented to you was largely managed by me.

PROF WHITEFORD: And the GP.

DR PRING: If I could rely - the original GP that referred that person has died, and there are other GPs, but actually I did notice in your submission the idea of further training of general practitioners to be able to perhaps look after the serious end of the spectrum better, and whilst my GP colleagues will criticise me for saying this, I actually agree that that would be very useful because I also personally, for instance, treat a number of doctors, including GPs, and when I ask them, 'How many GPs do you think are really interested in treating people with conditions like yours?' and they say, 'Maybe 5 per cent.' I said, 'What about 10 per cent?' 'No, probably closer to 5 per cent,' and I think GPs could do the job with us and allow us to see more people, use our expertise in that way, and I would love to see something akin to the Meadows model that's been used in Victoria in the public sector but funding wasn't continued. But it could occur in the private sector and through peer review groups of combined GPs, psychologists and psychiatrists, we could actually help increase the expertise in these community teams, and we don't need a huge administrative structure over us if it's cleverly organised through Medicare system and a referral structure of some sort that makes it possible, similar to the one that is illustrated in our main submission.

PROF WHITEFORD: Thank you.

MS ABRAMSON: I just have one question, Dr Pring. It's regarding regional and rural access, because we know that we have certainly shortages of psychiatrists in certain disciplines, which we've talked about, but in our report we were very concerned about how we can get services to people in rural and regional Australia, so I'm interested in your views on that.

DR PRING: Yes, I've got very firm views about that, and our group does too. We've discussed this a lot amongst ourselves. A number of us do telepsychiatry, telehealth. Our consultations almost exclusively are consultation-based service. Interestingly, I've certainly found that many rural GPs have the necessary skills to look after the end of the spectrum that I'm tending to treat and can implement the management plans that we might do through the system of 291 assessments that were set up in 2006. Can do that very effectively and can follow the management plan, so they've sometimes - the GP for me, for instance, has referred people back after three or four years and they're much improved but the GP is wanting to know what the next step is towards recovery for this particular patient. So that's a very satisfying thing both ways.

The other thing is I think the last really good study on the mental health needs of rural and remote populations was done by Burgess, and I think it came out in 2002, maybe. With all of the study, I can't remember now whether the study was actually done in 2002 and it came out later, but in any case, it was around that time, so that's a long time ago now, but to me that

was the last good study into what the actual needs are, and they gave a lot of raw data in their report and I went back and studied that and I won't go into all the details but the bottom line was a lot of the rural patients were being seen to a similar extent as the public sector, so we in the private sector actually, even before we had telepsychiatry we were actually treating people at a similar level, especially if you look at patients actually being psychiatrically assessed as distinct from - and I'm not trying to run down the mental health teams that work in those areas. They're usually very experienced and very good too, like the GPs in those areas. But not everyone gets to see a psychiatrist first-hand, and if you looked at that I think more people were probably seeing private psychiatrists than public psychiatrists.

But all I'm saying really is that we're important in the rural areas too, but one thing I have particularly noticed, and I've been doing the telepsychiatry, I suppose, since it began. I'm not sure when that was, but it's probably at least eight years or so now, and I'm noticing more and more people that I see in the country town that I'm mainly servicing who have moved up from the city. They're usually on pensions, they have multiple medical problems, not just mental health problems, and they're coming to the country because the living expenses are less and actually probably the medical system, until some of these good GPs retire, is reasonably good too, and the hospitals and the mental health nurses and CAT teams and so forth I think are at a very high standard compared to the city.

But they're going there but they're taking with them a lot of comorbidity and I don't think that's really been fully recognised, and I think we're about to hit - we're seeing a lot of crises that the fires and natural disasters are temporarily producing, but I think we're about to see a collapse, actually, of a lot of rural infrastructure, including overall health infrastructure, let alone mental health infrastructure, and just finally I'd just say that the introduction of NDIS seems to have decimated a lot of the mental health supports that were working previously in the country from going - I've been to the Royal Commission hearings, including a couple of ones in the country areas, and it feels to me like a lot of the mental health supports, have actually been supplanted by other cleverer people who are able to get into the NDIS system and we've lost a bit of capacity in that area as well.

MS ABRAMSON: Thank you. That's been really helpful. Thank you.

PROF KING: Thank you, Dr Pring.

DR PRING: Thanks.

PROF KING: You're going to head off?

PROF WHITEFORD: Yes.

PROF KING: Away, Commissioner Whiteford.

MS ABRAMSON: Thanks, Harvey. Are you coming to Sydney?

PROF WHITEFORD: See you in Sydney.

PROF KING: Just remember: three hours to the airport.

MS ABRAMSON: He's got his walking shoes on.

PROF KING: Next we have Julian McNally. If you'd be able to state your name and your affiliation for the transcript, then if you have any opening comments you'd like to make.

MR McNALLY: Sure. Julian McNally, ACT of Living, and I was simply going to read something I've written because I was given instructions about keeping it brief, so I thought I'll - - -

PROF KING: Yes, please do and then we'll ask some questions.

MR McNALLY: - - - type it up so I can keep it as concise as possible. So thank you for the opportunity to address the Commission, and of course thank you for undertaking the Commission and a very comprehensive draft report which I haven't read every page of. So I'm a principal psychologist of ACT of Living, which is a private clinic of eight mainly psychologist clinicians in Northcote, and our clients comprise mostly adults referred by GPs and psychiatrists for treatment under Better Access but also include those needing psychological treatment funded by bodies such as NDIS, WorkCover and TAC, and of course people who self-fund.

Since 2014 our practitioners have recorded session by session outcomes using assessment tools provided by the US-based Centre for Clinical Informatics headed by Dr Jeb Brown. The centre's customers comprise behavioural health care organisations, psychiatric hospitals, substance abuse treatment clinics and private practitioners and together they form a network of clinicians known by the acronym ACORN, A Collaborative Outcomes Research Network.

Since 2007, ACORN has delivered over 3 million questionnaires in more than 800,000 cases. The resulting database allows the ACORN tools to predict from a client's initial scores on the questionnaire how quickly they should improve, assuming competent practice, from their clinician.

One of the most important findings from the research the Centre for Clinical Informatics has conducted on these data is that clinicians who simply log into the system, presumably to determine their client's progress, are more effective than those who don't, so in one recent study they've stratified the clinicians according to the level of engagement with the tool. The high engagement clinicians are the ones who check in on the tool most frequently, low engagement rarely at all, and there's a sample of the statistics that you find from that study. A client of one of the high engagement clinicians, in other words someone at the 50th percentile, has a better outcome than about 57 per cent of clients in the low engagement group, so there's a marked difference just from clinicians paying attention to their outcomes.

What you get from that - the benefits - are obviously better outcomes resulting in shorter treatment times, fewer dropouts and greater value per dollar spent, and this is why the insurance companies love it. So our experience with these tools is, you know, if we compare ourselves to the ACORN database, I don't know how many clinicians there are in that, but 800,000 cases, not just hundreds or thousands, and so I like to call those people as a body the average clinician, or at least the average probably largely North American clinician.

So what we've achieved is greater improvement on average per client, longer engagement so an average of five assessments over the period of treatment versus 4.3, a longer treatment period: 12.3 versus 10.6 weeks, and we know longer treatments correlated with either lower dropout rate or more complete treatment.

We have a 50 per cent higher rate of improvement per week, so, you know, that's where we get the better outcomes. It's sort of like we're taking longer but we're getting more improvement each session, and a greater proportion of patients improving so overall improvement, not significant improvement: 73 versus 68 per cent, I think for significant improvement. Ours is about 56 compared to about 48, and by the way, extensive studies have looked at what's the level of improvement that you'd expect in an average population treated by an average clinician. It's about 40 per cent, so even the ACORN clinicians are doing better than average.

We've also got a lower proportion of severely deteriorating clients. Again, 4 per cent, the ACORN average is 6 per cent. Something I include in informed consent with all clients now is, you know, there's a chance that you'll actually get worse by seeing me, but hopefully it's less. By the way, the ACORN level of 6 per cent, I know when I looked at that three years ago it was 7 per cent, so that overall database is improving, and I'll refer in a little while to studies where the sort of standard expectation of deterioration is a bit higher than 6 or 7 per cent.

The other area we want to take this into is segmenting our database of cases so we have about I think it's 750 cases in our database by demographics and broad diagnostic categories so that we can provide a best-fit therapist for each client, so, you know, I have a selection of eight therapists. When I found out who's good at what, we can start getting a good fit between therapist and client, and I think that's important, so rather than base it on, as is usually done in private clinics, it's either the in-take manager's intuition or a particular therapist saying that they're good with a particular client profile, or just that they have an interest. We'd like to see it based on, 'Are you actually any good working with this demographic of client or this diagnostic category?'

So I had a quick look at my results before I came in and apparently I'm much better with anxiety treatment disorders but I'm not the best person to see for depression.

I think the benefits of getting widespread use of outcome questionnaires such as the ACORN tools would accrue to almost all stakeholders involved. Now, this is the sort of explosive statement, so stand back. There would be a global increase in standard of care due to workforce attrition of the least affective practitioners. In other words, if you knew a practitioner was in the bottom 10 or 20 per cent, why would you see them? If the practitioners knew that, maybe they'd actually leave and find a career that they're more suited to.

I'm saying that as a former salesman that was, like, barely average but got by. I'm much happier working as a psychologist and I'm probably I think a little bit better than average.

Outcomes would improve for the majority of practitioners, not just those already using the

tools. I know you've been exposed to the sort of conflagration over the divisive multi-tier system in Medicare. That could actually be retired and replaced by an outcomes-based payment system or at least a rebate system that didn't depend on or wasn't segregated by training, professional affiliation, et cetera.

If we were able to ensure that clinicians linked client diagnostic categories to treatment progress and then published their outcomes across diagnostic categories, it would allow clients and treatment funders to pay for the best available treatment, you know, again, rather than depending on networks.

Deterioration and adverse event rates could be lowered. I see you've had many submissions from carers and consumers distressed by what happens when you go seeking treatment and you actually end up worse, which is not always the practitioner's fault, but, you know, it happens, and if there's a way we can direct it we should.

The research on this is really troubling because without measuring outcomes and deliberately looking for deteriorations, clinicians are actually hopeless at detecting it, so I'm just going to give you some results from a couple of studies. In a sample of 49 psychotherapists, clinicians markedly overestimated their rates of positive client outcomes. They estimated them at 91 per cent, and as I said, the average is about 40 per cent. So generally you go and see a therapist of some kind, 40 per cent of the time you'll get a good outcome, but most therapists seem to think that about 91 per cent of their clients will.

When clinicians in the study were actually told in advance that the population they were seeing had an overall deterioration rate of 8 per cent and were then asked towards the end of the study or after the end of the period of treatment to go through their files and estimate which clients had deteriorated, out of 550 cases they nominated a total of three cases - in other words .5 per cent - as deteriorating, and they'd been told that 8 per cent would. These people are highly trained in statistics, remember. So it seems we're not particularly good at that.

In another study, a sample of 129 therapists in private practise - so the study I just referred to is a variety of counsellors and therapists at university counselling centres. So the average clinician rated him- or herself at the 80th percentile of all therapists. I found this quite humbling. I'm sort of somewhere between 60 and 70 per cent and on a good day towards 80 per cent, but mostly, like I said, I'm a little bit above average but nothing to get a big head about. None of them rated themselves as below average. Remember the statistics training all these people have done.

The typical therapist in the sample estimated the rate of client deterioration in their own caseload to be 3.7 per cent, so about half what you would actually expect. So what I think has happened with the ACORN therapist, and this is something that Jeb Brown has written a couple of research papers on, is that they simply check and pay attention to where the clients are improving. On a not-quite-objective basis, it is the client's self-report, but it's a little bit like we sort of run a mile from a doctor who didn't check your weight, blood pressure, blood sugar levels. So I wonder why we aren't doing this in our field.

PROF KING: I think you're talking to the converted. Is it possible to get some of the

references you referred to?

MR McNALLY: Sure.

PROF KING: The studies and so on. The ACORN outcome monitoring; they're specific measures that ACORN used rather than standard assessment tools?

MR McNALLY: Yes, what they've done is taken - I see you referred to Michael Lambert somewhere in one of the recommendations.

PROF KING: (Indistinct) 1,280 (indistinct).

MR McNALLY: Yes. You haven't read them all.

MS ABRAMSON: No, we have read them all.

MR McNALLY: He produced an instrument called the OQ45, so it's 45 items, it's been heavily researched and he's probably the leading person in his field of, you know, monitoring outcomes and feedback-informed treatment. Jeb Brown basically condensed that to the - he provides a number of tools, some for adolescents, some for Spanish-speaking people, some for, um, people with alcohol or gambling problems, but the one we use is a kind of general one. It's like a 12 or 13 item distillation of the 45 item one.

So we have no problem having clients complete that. Private practice setting and, you know, they're highly motivated of course, but I think it can be done in other settings and, you know, the other ACORN practitioners are doing it.

PROF KING: How do you actually do that as a matter of - is it that it takes some time out of the formal 50 minutes/hour of the session or do you ask them to fill in whilst waiting before the session, or what's the mechanics of that, because that will be an immediate response. Well, you're taking up therapeutic time filling out a form.

MR McNALLY: Yes. I've dealt with a number of therapists offering that objection and that was back when I was using a simpler measure that just had four items and you'd just cross somewhere on a line.

PROF KING: Yes.

MR McNALLY: This is like five-item responses. So we have people who do different things, so sometimes the receptionist hands it to the client when they come in and, again, once they're used to that's part of the procedure, they do it. We provide the rationale for it in the first sessions. I tend to hand it over in the session. It also has three items at the end that the client completes that are basically feedback on the session.

Now, again, I think a lot of therapists say that they ask for feedback. This is a way of actually getting the feedback directly and of course the idea is, you know, if you measure it, pay attention to it. So if you see something is out there - like, I have picked up people sometimes with an alcohol problem that, you know, hadn't been disclosed in the first two

sessions, but then they start saying, 'Someone's worrying about my alcohol consumption.' Or self-harm suddenly crops up, so it does have some assessment value rather than just being a four-item test I measured before. It's just a, 'How are you feeling?' You know, 'How are you functioning socially?' 'How are you functioning individually?' This is a bit more targeted.

It also has these other benefits, so one particular WorkCover case that the insurer was recommending that the person attend less frequently or actually cut off her insurance, I was able to show that when we'd had a previous period with greater gaps between treatment sessions she deteriorated; when we picked them up again she'd improved. It was almost like a field ABA design, and that resulted in the funding being reinstated. So I don't understand why anybody would not want to do it. Sorry, have I answered your question?

PROF KING: Yes, you have. That's good. Although, again, just in terms of time is it like five minutes in general or - - -

MR McNALLY: It takes about two minutes. You know, two or three minutes.

PROF KING: Has there been any work done on the different ways of presenting the outcome measurement to the consumer or the client and whether that has an effect, so I was wondering, you said you passed it across. So if you have the client fill it out in front of you, I wonder if that leads to different outcomes than if they're passing it onto a receptionist or something?

MR McNALLY: I can't name anything, but I think something has been done on that. Yes, one of the risks, and I think this is what you're talking about, is that, you know, the client wants to please the therapist.

PROF KING: Yes, yes.

MR McNALLY: Or if the clinician is working for an agency, the client may be concerned that the boss is going to, you know, grade or performance appraise the clinician based on what they say so they say good things even if, you know, the therapist isn't performing well. But, no, I - - -

PROF KING: Don't know if there's been work on that.

MR McNALLY: I think some research has been done but I don't know where.

PROF KING: Just in terms of actual concrete recommendations, so have I got it right? One recommendation you would like us to make or feel that it would be useful to make is outcome monitoring at every session is part of Better Access?

MR McNALLY: Yes, yes.

PROF KING: Yes, and again, just making sure we're both - - -

MR McNALLY: Yes. No, I think you've got a recommendation in there about, you know, what - or sorry, a request for more information about what should we do to mental health

treatment plans.

PROF KING: Yes.

MR McNALLY: This is something I provide the data on the GPs when I send my six and 10 session letters. Don't get a lot of feedback from GPs about whether that's useful. I just feel like it's a, you know, very quick way of giving a visual summary of how the patient is going, but, yes, I would definitely like to see everybody doing that.

PROF KING: Okay, and the second recommendation that you'd be interested in us making would be that the outcomes data should then be publicly reported and available to consumers and presumably GPs and other professionals; anyone interested, basically. And that should be done on what diagnostic basis?

MR McNALLY: Well, probably all. Like, I can't see a disadvantage.

PROF KING: There have been issues - putting out public information is, for example, done in England. It's also done in some parts of the US for different specialisations outside of mental health.

MR McNALLY: Yes.

PROF KING: I don't know of anyone who does it in mental health. The issue becomes the risk rating and the potential for cherry-picking, so, 'Ah, well, I've got two clients both who formally have depression, but one is going to be much easier to treat than the other, so I treat the one who's easier and the other - the one who's harder to treat I say, "Look, I can't see you by -".'

MR McNALLY: Yes. Well, I'm in two minds about that because on the one hand I think if we're not good at detecting deterioration maybe we're no good at even making that estimation. On the other hand, I supervise a number of psychologists and, you know, it's quite clear, like, everybody sort of says, 'Oh, I don't want to touch someone with borderline personality disorder,' or 'the more severe eating disorders,' or whatever.

PROF KING: Yes.

MR McNALLY: I don't know. I think, yes, you can take that either way and perhaps there might be some areas where we say, 'Look, nobody is going to treat borderline personality disorder if they know, you know, the outcomes are so hard or treatment resistant depression,' or whatever.

PROF KING: Yes. Well, that's by a diagnostic group. I was actually thinking within diagnostic groups, so within a particular - you know, that's why I picked depression.

MR McNALLY: Yes.

PROF KING: So you can get your ratings up by dealing with somebody who may have depression - - -

MR McNALLY: Okay.

PROF KING: - - - but it appears relatively mild, there's no comorbidities and so on versus somebody who has depression but may also have diabetes or, you know, becomes a more complex patient.

MR McNALLY: Yes. I never cease to be surprised by what clients pull out when I think that it's going to be an easy case.

PROF KING: Yes, yes.

MR McNALLY: But, no, ACORN actually has something built in for that. So the effect sizes I was quoting before are severity-adjusted effect sizes.

PROF KING: Okay.

MR McNALLY: So you know, you take into account where the person is starting, so the smart thing to do is actually start with them when they're really in a crisis because their - you know, regression to the mean. They'll probably improve anyway.

PROF KING: That's right. True.

MR McNALLY: That's being really cynical about it.

PROF KING: Yes. 'I'll see you in four or five weeks when you're really - ' but it is a serious issue because - - -

MR McNALLY: Yes.

PROF KING: - - - when I said, 'You're talking to the converted,' the Productivity Commission previously recommended exactly the sort of reforms that you're talking about not just in mental health but more generally, so I'm really raising issues that were raised with us at that stage. Sorry, I am dominating the conversation.

MS ABRAMSON: I think bearing in mind the timeframe, Mr McNally, I might ask you to take the questions on notice if you intend to put a submission in perhaps to our inquiry. The first question really was about the cultural change that would be needed, so if psychologists aren't doing this type of assessment now, and I can understand why they mightn't be doing it, we would have to drive a very big cultural change program to get people to actually perform. It's not just psychologists, it's in the medical profession generally, so your thoughts on how that might be done would be very useful.

MR McNALLY: Okay. Yes, I see it as needing to be sort of like a multi-pronged attack. In other words, you know, even the training courses like the universities and schools of psychology and social work and, you know, nursing and whatever.

MS ABRAMSON: You might give some thought to that and the education that we have.

That would be terrific. The second question goes to how well those type of instruments would measure interactions with people of diverse cultures.

MR McNALLY: Yes.

MS ABRAMSON: So we're talking about a particular form of measurement which is associated probably with a western type of culture, so your thoughts on that. The other thing is also funding around a team-based approach in the private sector, so any ideas that you might have on how you do some of those things would be very useful. But happy to take those on notice.

MR McNALLY: Yes, okay.

MS ABRAMSON: And I've committed you to a submission, so if you're not in that position, just give us a call.

PROF KING: We strongly encourage you. We'd love a - - -

MR McNALLY: Consider it started.

MS ABRAMSON: Thank you so much. Thank you. Thanks, Steve.

PROF KING: Great, okay. Thank you very much. Then Prue Lynch. Thank you. Would you like this to be treated as a formal submission, by the way, or are you planning to read this out for transcript?

MS LYNCH: I'm reading this out.

PROF KING: No, that's good. In that case it will be on the transcript. That's fine, thank you.

MS LYNCH: Okay.

PROF KING: So if you can please just - your name, the role in which you're appearing and then any initial comments that you wish to make on transcript.

MS LYNCH: Good afternoon. I'm Prue Lynch, I'm a counsellor registered with the Australian Counselling Association, which I'll subsequently refer to as ACA.

Just a little background about myself: I have four years' study in psychology and a masters in counselling from Monash University and I'm a recipient of the Golden Key Award for Academic Excellence. I'm also trained in a multiple of therapies with proven results, and the Australian Counselling Association have told us stick to the draft, so excuse me as I go through and say on this page or that page or whatever.

So I refer to the draft volume 1 at the very start it says, 'One in five Australians experience mental health each year and the cost to the Australian economy is conservatively in the order of 43 to 51 billion per year.' It's my belief that counsellors registered with the ACA could

provide a great role in helping to provide cost-effective excellent professional and proven therapy to those experiencing mental ill health. But to do so, we need to be granted Medicare rebate provider numbers, and shamefully we are not. I think it's shameful.

Because most counselling agencies will only employ health providers - well, generally will only employ health providers with Medicare rebate numbers, counsellors are often locked out of providing help that is desperately needed.

Page 6 of the draft looks at key driving factors for poor outcomes in mental health. For example, under-investment in prevention and early intervention. Counsellors are outstanding at providing a psychoeducational therapy and wellness therapy for a vast range of issues which help problems from escalating in clients.

Many reforms need to be - and the draft then says, 'Many needs to be implemented in stages, and quickly.' It's my belief that at the very start ACA counsellors, especially with degrees, should be granted Medicare rebate provider numbers.

The draft also recommends early intervention including tackling early mental health and suicide rates. For example, when I was doing my masters, I had a year placement at a counselling agency which provides therapy for many clients with suicidal ideology and also the families who have loved ones which have committed suicide. Many ACA counsellors have also got experience in effectively counselling those clients with suicide ideology and their families.

Throughout my academic years, I have undertaken intensive study of stress, anxiety and depression, mindfulness and other associated studies in the identification of risk factors, and one of the draft - refers to the necessity for early identification of the risks to mental health of families and children.

It then goes on to look at suicide prevention and refers to a recent study which concluded that after care could reduce the prevalence of suicide attempts. I have been swift and active in educating clients about the systematic steps to take after a suicide attempt, or when they have experienced a suicide ideology. That might've been a bit dramatic, but I've been there, I've done that, and I've been effective, even though I don't have a Medicare rebate provider number.

Furthermore, I have been active and systematic in my communication with other care providers, to ensure excellent after care. And some of those other health providers, the psychologists, psychiatrists, basically by sharing what I found out with the clients, I'm able to help the psychiatrists tailor what medication will be presented.

The draft then also talks about access to psychological therapy at a level commensurate with the treatment levels. Throughout both volumes of the draft, the word "psychological issues" - and this implies a psychologist - it is vital that the draft reflects the critical role that ACA counsellors provide in mental wellbeing, and their potential if given a Medicare rebate provider number.

I feel like I've got a record playing, sorry. The draft also discusses person-centred care, which should be consistent. Research indicates that - quite a lot of research indicates - that approximately 32 to 33 per cent of successful therapeutic outcomes are due to the relationship that a client has with a therapy provider; this is regardless of the modality that they use. ACA counsellors are especially brilliant - if I may say so myself, but also from my experience - and develop empathetic, professional relationships with clients.

The draft then goes on to refer to the step model of care; in the step model of care, it fails to use the word "counselling," and again, I think dismissing any role of counselling or therapy, rather uses the word "psychological." I've certainly got the background in psychology, but I want to make sure that we're very aware of the opportunity that the ACA counsellors can present.

The draft then goes on about the strength of the Better Access Program is the ability to fund services at comparatively low cost. ACA counsellors would provide lower costs than psychologists. And it talks about the many interconnected determinants of mental health, which is found in the diagram on page 119. Again, counsellors are part of the determinants to reduce mental health in clients.

It also talks about the socioeconomic disadvantages, which has strong links to mental health and wellbeing. Many counselling agencies in Australia are financially struggling, and basically employ whoever has a Medicare rebate provider number, to provide their counselling, in order for them to survive. ACA counsellors are able to provide Medicare rebates to client; could help reduce the cost of hiring psychologists at an earlier level, and provide outstanding results.

And on page 47, the draft talks about "providing more bang for taxpayers' buck." I believe by providing ACA counsellors with Medicare rebate provider numbers, we can help to provide more bang for taxpayers' bucks.

PROF KING: Thank you. I'd like to follow up. We've heard from a number of different groups, including counsellors, other forms of therapists, and there seems to be a uniform call that, "Things would be better if only we could get Medicare provider numbers." And that obviously creates an issue from the government's perspective. We know about supply-driven demand in healthcare systems, so you can imagine that we'd be reluctant just to say, "Yes, open the floodgates to a whole range of different groups for Medicare provider numbers."

So my first question is, particularly given the previous presenter's comments, one way that we could judge who gets Medicare provider numbers is based actually on performance, on outcomes. So I was wondering, are you aware of any outcome-based evaluations of counsellors? Of particular interest would be outcome-based evaluations to compare the outcomes for counsellors versus the outcomes for other allied health professionals involved in providing face-to-face therapy. In a sense you've said, "Well, counsellors get outcomes." How do we know?

MS LYNCH: I don't know of any particular comparison. I do know that counsellors are - and this is not very professional - are a little bit - no, I'd better not use that word, there -

frustrated, because we can't get in there as much as we would like to, to be even able to provide probably, those figures, or a comparison.

I'll give you an example: I've been working at a Uniting Agency in Geelong. We used to be Wesley, and until we were taken over, even though I didn't have a Medicare rebate, I was given clients. I've been sitting through so many meetings in my staff, staff meetings, and my numbers have dwindled and dwindled and dwindled, of my clients, and I'm literally pulling my hair out because I'm not getting clients.

And the only thing that I can say, I know that two weeks ago, I did save somebody's life; I implemented so quickly - that's why I went like that - because damn it, I did that. I implemented a strategy to help make sure this person would survive. So I'm sorry, I can't provide those figures, because I just don't get the clients, and I don't think many of us who are outstanding are getting enough clients, because - - -

PROF KING: Yes, and it may be something that the ACA really needs to deal with at a larger system level.

MS LYNCH: They've - - -

PROF KING: Making sure they get that data.

MS LYNCH: Philip Armstrong, our president, has been knocking on government doors and health ministers for years and years and years. And I'm here; I want to kick your frigging door in. I know that sounds dreadful, but I think it's time to kick a door in to make sure that we're noticed, because we've been pussy-footing around and I don't think that where universities are churning out counsellors like anything, and counsellors of the calibre that I am, we are not - we've got our hands tied.

PROF KING: Behind your back, yes.

MS ABRAMSON: I suppose what Commissioner King was really getting at was more your industry peak association to provide, if they can, some data on effectiveness. So what Commissioner King was really talking about was if we have to allocate public funds - we've said this about a whole range of programs: we've asked for evaluations, like, how effective is it? Because that's part of the decision-making, so that's really what we were asking.

PROF KING: Yes.

MS LYNCH: Okay. Well, given that, I can't personally provide it.

PROF KING: No, no.

MS ABRAMSON: No, no.

MS LYNCH: But what I would like, if I could have some questions sent to me, to my email, I will make sure that the president gets back to you with those.

PROF KING: Okay.

MS LYNCH: So I think he will be much more effective in doing so than I would.

PROF KING: Okay, that would be fantastic. So we've got your email, so yes, Jane's nodding down the back. And again, this may be one that you want to pass on to the ACA: you mentioned that counsellors would not be as expensive as psychologists; any thought on what the MBS rebate would be for counsellors? So for registered psychologists I think it's around \$86.50 an hour. I'll look down at some people; yes, they're sort of saying that sounds about right. I think it's \$86.50 an hour for registered and about \$125 for a clinical, off the top of my head. So any thoughts on what the rebate would be for a counsellor?

MS LYNCH: Well, my thoughts are, if we did get a rebate, if we're fair dinkum about it, because we are not psychologists, I think we would need to be guided by the president, or by the ACA.

PROF KING: Okay, so - - -

MS LYNCH: And come up with a figure. But maybe - - -

PROF KING: That's another question that we can pass on. That's fine.

MS ABRAMSON: And because one of the things, Commissioner King, we will probably look at is where rebates are provided by private health insurers; that might be part of the mix, too.

PROF KING: Yes.

MS LYNCH: Well, basically, I don't know that that many people are at the ACA are actually getting a lot of clients coming in with the rebates.

MS ABRAMSON: No, I understand that. I understand that.

MS LYNCH: With private rebates, though. But maybe the rebates are so flimsy? For example, a Medibank Private might say, "Oh yes, you can get a rebate." But then you look into the actual policy you've got and you don't actually get it, or it's - - -

MS ABRAMSON: No, we understand there can be issues there.

MS LYNCH: Yes.

MS ABRAMSON: Thank you.

PROF KING: Any other questions, Julie?

MS ABRAMSON: No, thank you.

PROF KING: Okay, thank you very much.

MS LYNCH: Thank you very much.

PROF KING: So thank you all for attending today. I will now adjourn the hearings, to be reconvened - if any of you wish to join me - in Geraldton, tomorrow.

MS ABRAMSON: And can we also, on behalf of the Commissioners, thank the Commission staff?

PROF KING: And thank the Commission staff.

MS ABRAMSON: For their huge amount of work that they've put into the hearings.

PROF KING: But they're all going to be with me in Geraldton tomorrow.

MS ABRAMSON: They're not looking too enthusiastic about the big night flight to Perth, Commissioner King.

PROF KING: Right, thank you very much.

MS ABRAMSON: Thank you, thank you very much.

**MATTER ADJOURNED UNTIL
WEDNESDAY 20 NOVEMBER 2019**



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

PROF STEPHEN KING, COMMISSIONER
MS JULIE ABRAMSON, COMMISSIONER
MS AN TRAN
MR ALISTAIR DAVIDSON

TRANSCRIPT OF PROCEEDINGS

AT THE GERALDTON CLUB, 160 MARINE TERRACE, GERALDTON
ON WEDNESDAY 20 NOVEMBER 2019

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PROF KING: All right, let's get started, folks. 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 I'm the presiding commissioner on this inquiry. With me up here I have An Tran, Alistair Davidson is at the back, and on the phone, we have Commissioner Julie Abramson.

Before we begin today's proceedings, I would like to acknowledge the Southern Yamatji peoples for the traditional owners and first people of these lands. They are Nhanhagardi, Wilunyu and Amangu. I would like to pay my respects to elders, past, present and emerging, for they hold the memories, the traditions, the culture and the hopes of the Southern Yamatji peoples. I extend this respect to all Aboriginal and Torres Strait Islander peoples in attendance today.

The purpose of this round of hearings is to facilitate public scrutiny of the Commission's work and to receive feedback and comments on the draft report. This hearing in Geraldton is one of many around Australia in all states and territories and the capital cities and regional areas.

We will then be working towards completing a final report to government in May, when we've considered all the evidence presented at the hearings and in submissions, as well as other formal 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 reports released by government, which may be up to 25 parliamentary sitting days after completion.

We will conduct all hearings in a reasonably informal manner, but I would like to remind participants that there are clear structures in our legislation for how these hearings are legally backed, and a full transcript is being taken. For this reason, we cannot take comments from the floor, but I will allow time at the end of today's hearings, or otherwise during the hearings, depending on the schedule, if anyone who hasn't formally registered to speak wishes to speak. If you wish to do so, by the way, have a chat, probably with Alistair down the back at some stage, so we can pop you into the schedule.

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 the issues raised in other submissions; I'd also ask participants to ensure their remarks are not 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; there is a quiet space outside on the balcony out the back. If, at any time, you feel distressed, please approach one of our staff, who will assist you. We also have Leanne Prirottina, who's just had her hand up; a clinical psychologist from 360 Health + Community, who is available to provide support if need be.

In the unlikely event of an emergency requiring evacuation of this building, please head out the back door, across the balcony and down the stairs to the carpark. And toilets are located out this door that you came in, to the left, down the corridor; I assume that means that way.

Yes, that way and down the corridor. If you require assistance, please speak to one of our inquiry team members here today, so An and Alistair.

Our first participant today is going to be a representative from HelpingMinds, and I invite them to come up, join us at the table. And just for the transcript, if you can state your name, your organisation, and any opening comments that you'd like to make.

MS CHILDS: Okay, thank you. My name is Deborah Childs and I'm the Chief Executive Officer of HelpingMinds.

HelpingMinds is a not for profit mental health and carer support provider, delivering services across WA and Darwin, for both adults and children. We started as a ARAFMI, the Association for the Relatives and Friends of the Mentally Ill, over 43 years ago, and we understand that having a loved one who is experiencing mental ill-health can be a difficult and isolating experience.

HelpingMinds has 11 offices throughout WA and one in Darwin, and a team of over a hundred team members to provide support. We have a diverse group of team members from many cultural backgrounds, and over 75 per cent of our team have either their own lived experience of mental ill-health, or lived experience as a mental health carer.

We offer a range of social, emotional and practical supports, that is, psychosocial supports, and that help individuals, families and friends, and carers cope, during stressful times. And we work directly with families and friends to assist them in sustaining their ongoing caring role, and also work with individuals who require support as a result of a mental health issue.

I can go into greater detail and I will; we will provide a written submission, so to keep it concise: to help deliver wraparound supports, we partner with a number of clinical services, both community mental health headspaces and in-patient mental health units in WA. And in the last 12 months, we've engaged with over 25,000 people throughout WA and the Northern Territory.

According to the ABS, the number of family members and friends in WA providing care to a person with a disability due to a psychosocial condition has been estimated to be around 61,000; however, academic research has suggested this figure is a considerable underestimate. And approximately 15 per cent of all Australian adults are providing care or support to a family member with a mental health issue. And there are many young people, including children, who are also in an ongoing caring role for their parents and other family members living with a mental illness or, using the NDIS vernacular, psychosocial disability.

HelpingMinds welcomes the Productivity Commission's draft report, and feels it is an excellent opportunity to re-evaluate Australia's mental health service system, beyond the medical and clinical framing of mental illness and medical interventions. We also intend to provide a written submission prior to 23 January 2020.

We feel the report is heading in the right direction, and offers welcome reforms to the mental health system. HelpingMinds also supports the submissions of both Mental Health Australia

and Mental Health Carers Australia, and we also support the Time to Fix Mental Health campaign with Mental Health Australia.

The insights that we'd like to offer to the draft report come under two broad headings; the first heading is a rather long heading: "Carers, Families, Friends and Young People." And the second is, "Workforce." So, I'll start with the second, the workforce.

Overall, this draft report is structured around the service planning framework, which highlights the clinical and biomedical, and we feel misses the understanding and need for psychosocial supports, in being an holistic part of mental health recovery.

There needs to be recognition of the need to balance the system, both clinically and in a community mental health setting. There is significant cost in hospital stays, both financially, emotionally, and traumatically. Community mental health focuses on in-community support, so that allows a recovery and relational approach.

In our opinion, the final report needs to provide a greater emphasis on the relational-based approach to recovery for all Australians who are affected by mental ill-health. The final report needs to provide a greater focus on social and emotional wellbeing for everyone living in Australia, and more focused on the social and economic determinants of health, to ensure ongoing recovery.

It is our recommendation that the Productivity Commission looks at the workforce through a lens of relational recovery and citizenship, therefore addressing the social determinants, as much of this is emotional support and therefore mitigating the fallouts of some of the ineffective systems that are currently in place, that don't currently work with psychosocial supports.

We recommend utilising the community managed sector in partnership with government, clinical and medical services, embedding a collaborative model so that community mental health employees are entrenched within the services; an example of this successfully working in WA is the collaboration HelpingMinds has with the headspace providers throughout WA, which supports family members when a young person is having support through the headspace. Separately, at Royal Perth Hospital Community Mental Health Unit, we provide psychosocial supports alongside the clinical and medical interventions.

We also endorse that there is a need for greater investment in recovery colleges and integrated employment services, including for family and carers. These allow self-empowerment in recovery; they can assist with resources, rights, roles, relationships, and responsibilities people need to regain their citizenship, including their family members.

A current example is the Broome Recovery College in Broome; this is a collaborative community model, with community mental health and non-government agencies such as HelpingMinds, working together to provide an alternative and additional support to traditional mental health supports. It is an educative and empowering model providing immediate benefit to the Broome community, when it rolled-out over 12 months ago.

The draft report has gone into detail on some workforce issues, and we seek further recommendation to address the challenges of recruiting and retaining specialised mental health community support workers. This has always been an issue in regional and remote areas, and now, with the changing individualised funding, is proving an issue in central areas like Darwin and Perth.

We welcome the recommendation to strengthen the community health and consumer carer/peer workforce, and see this as a positive step forward in the provision of recovery-focused mental healthcare. However, as mentioned previously, we see a significant gap in the report in relation to community-managed organisations' workforces.

The current community-managed workforces, as I mentioned, faces significant challenges, and HelpingMinds, as an employer, is facing increasing difficulties in the recruitment and retention of suitably trained staff; this is particularly highlighted at the moment in the regional and remote areas of WA such as the Gascoyne and Pilbara. In addition, we feel a more formal recognition of the importance of consumer and carer/peer workforce is required, along with a framework to guide employers, as happens with other roles such as counselling and psychology.

With regard to psychosocial supports, people do ask for face-to-face supports in regional areas, however, online supports do allow confidentiality in small communities, so people aren't going into an office to have a session. However, that does require reliable access to the Internet, and also, we found that in small communities there is not necessarily the understanding or the technology available to do this at all times. We do find that a relational approach with an in-person support worker is most effective.

We certainly welcome the recommendation to lengthen community-managed contracts to five years. Our ask for the workforce area is recognition of the importance of community-managed workforce in providing psychosocial supports in recovery, and within our written submission I will go into more detail, but I don't want to take up time today.

Throughout the report, we call for increased focus and investment in integrated services where clinical and psychological supports are delivered in partnership between public and private, government and non-government mental health systems, and more investment in a dedicated carer and family workforce. And finally under workforce, development of a national co-production framework to guide how families and carers can work in partnership with the government and non-government sector.

The second topic is carer and family inclusion. So HelpingMinds supports the recommendations related to carer income support and the 25-hour rule. The dedicated family and carer chapter in the detailed report captures many key family and carer challenges and opportunities well, however, we didn't feel they generally translated through the recommendations and reforms. We'd like to see family and carer element integrated throughout the report, rather than as an add-on.

We'd like to ensure that families and carers are also involved in all aspects of service design, with a true co-design approach needing to be undertaken at all levels of mental health supports, whether clinical, medical, or psychosocial. To that end, mental health carers have

expressed to us their disappointment in the loss of mental health respite carer support funding program through the Department of Social Services.

Respite is essential for carers to maintain their caring role in a sustainable manner. The integrated carer support service - this is the new online service through the Department of Social Services - is a good concept, however, as a consortium partner to deliver the IDP in Western Australia, our financial modelling shows the amount of services available through the allocated funding will not provide sufficient services to mental health carers, as and when required.

Also, the ICSS program is for all carers, and mental health caring does differ from aged caring and physical caring. In addition, it is vital that mental health carer services are not lost due to the introduction of the ICSS at a federal level. Should state funding be lost, a significant gap will emerge for people in a mental health caring support role.

Our next point is with regards to clinicians, GPs, psychiatrists, mental health nurses, and how they engage with families and carers of their patients. We feel a change in culture in mental health services, where the hospital or community and NGOs is needed, in respect to carer and family engagement. This can be achieved by the final report recommending - or preferably mandating - this cultural shift to carer-inclusive practice be included within quality and safety standards.

We have a co-design tool - which I have brought copies of to leave with you - to assist in the implementation of a change of cultural practice to carer-inclusive practice. The practical guide for working with carers of people with a mental illness was a major co-design project between five not-for-profits throughout Australia, and it used a true co-design model: it utilises the triangle of care to ensure effective communication between the consumer, carer and clinician.

From a lived experience perspective, this would benefit all involved; from my own lived experience, there is nothing worse than being called as a carer to collect your loved one that has been discharged from hospital, and when you ask, "What medication regime, what do I need to do?" and you're told, "They just need somewhere to go, they just need somewhere to stay. Don't worry about it, we've told them all about the medication," and then a few days later, they are suicidal again, that doesn't resolve anything. And going around in circles.

People are being discharged in some cases - and I'm not saying in all case - but in some cases, without due care. And if there aren't carers at home, such as myself, that can lead to homelessness, an interaction with the justice system, and in the worst outcome, it could be the untimely death of that individual. And from a personal experience, you know, something needs to be done.

Therefore, HelpingMinds and myself, as a mental health carer, recommend to you that serious attention be paid to the practical guide as it can effectively provide a mechanism to allow for cultural change that is required around family and carer engagement, resulting in better outcomes for everybody involved. We also recommend a recommendation around strengthening the Carer Recognition Act.

We've got a brief comment regarding wellbeing leaders in schools. So we welcome this initiative, but do wonder if it would be better embedding a wellbeing specialist from a community-managed organisation, as this would allow for better collaboration and integration between the educational settings and the community. It would also allow students to seek supports outside of school hours, and allow teachers to focus on their core remit of education.

Teachers are already stretched in their role, so why don't we play to people's strengths and provide qualified mental health professionals to provide this early intervention wellbeing supports to schools?

In effect, there is a Department of Social Services funding currently for early intervention supports for young people at risk of developing a mental health issue; HelpingMinds runs these programs in Kununurra, through the Kimberley and through the Gascoyne, midwest and Perth, and the Swan. So children that are identified at risk, we're able to work with; if that was opened up to the general population of the school - that's a similar initiative - it would probably be very effective because we found great effects in the service that we've been providing that way for the last six years.

So our ask, in the area of carer, families, and young people is, we believe a cultural shift to carer-inclusive practice must be informed in every setting, whether clinical or community-managed, and by implementing or utilising the practical guide for working with carers of people with a mental illness. Without our written submission, we will make a recommendation for a change or addition to draft recommendation 13.3; so we'll provide that.

The second request is the development and application of a national co-production framework. There needs to be more attention to the involvement of families and carers in all aspects of system design. And thirdly, the missing family and carer voice is a critical component to a new reformed system. We call for all family and carer voices to not only be heard, but systematically seen and included in services and recommendations throughout the report.

In finishing, I would like to add that one of my favourite sayings is from Einstein: "If you always do what you've always done, you'll always get what you've always got." This Productivity Commission gives Australia the opportunity to review what we've been doing and look for ways to improve, so that every person living in Australia has the ability to live a good life, with the supports needed, as and when they need them.

We need to remember that Australia is large and diverse, and what works in Canberra or even Perth will not necessarily work in regional and remote WA. We acknowledge the recommendations for regional commissioning, however, are slightly concerned how this would integrate with federal, state and PHN commissioning, and we need to ensure that another level of complication is not added to an already crowded commissioning space. Streamlining federal and state funding with fewer points to place blame would, in our opinion, be optimal.

HelpingMinds appreciates this opportunity to provide the oral submission today, and I'd like to end by thanking the Commissioners for the draft report, and we really look forward to seeing the final report in May.

PROF KING: Thank you very much, Ms Childs.

MS CHILDS: Thank you.

PROF KING: Let me lead off the questioning. One of the issues you raised - and it has caused us some discussion internally - which is around where consumers, carers, the network, the support network that individuals need to be able to stabilise to recover from mental illness. And the reason why we've had this discussion is that it is a balancing act, in the sense that we want consumer-centred care, recognising consumers need support, and recognising that there's a risk of when you say, "Well, the support becomes the centre, so you end up with the consumer and carer-centred system," that you actually disempower the consumers.

And that is a discussion that we've heard from others, and we've also discussed ourselves. So in our draft report, we were very careful; we said, "The consumer is the centre, it's consumer co-design, it's consumer input, with the assistance of the support network." But it is not, I think to use your words, you said "a consumer and carer co-design." And so we've been quite explicitly saying, "That's not the right way." Now, that's obviously against what you view.

MS CHILDS: Yes.

PROF KING: So please push back on. Why isn't carer co-design, why isn't that disempowering to consumers?

MS CHILDS: In my opinion, and with lived experience as a carer, I would suggest that every person is not an island, and so we need to - utilising an holistic approach with consumers and families, and a wraparound support working together, would provide better outcomes. I mean, I'm well aware of the debate between, you know, there's the consumer movement and the carer movement; I appreciate that.

And maybe I am naïve in my thoughts, but I think it would be really good for people to actually work together and provide supports together. When carers are excluded from care, they are at a higher risk of developing their own mental health issues, so then that could exacerbate the need for more mental health supports as well. So by working together - and it may not be right for each and every situation, and you know, you can't have broad brushstrokes; you actually need to look at situations and make recommendations on what suits a particular area or a particular cohort of people.

PROF KING: Okay. I think you're exactly right by the way, when you say it depends on the situation, because we have heard from consumers who have said, you know, "I wanted my carers, specific people, to receive the information but it seems that that's impossible." But we've also heard from consumers who have said, "Well, I actually don't want this person getting the information," you know, they're feeling disempowered because of the relationship with the person who considers themselves their carer.

MS CHILDS: Yes, yes.

PROF KING: Sometimes, then the consumer doesn't quite see it that way.

MS CHILDS: That's it, yes, yes.

PROF KING: So how do we get the flexibility in the system to make it that - again, it comes back to the consumer-centred element: how do we get the flexibilities of the consumer is able to say, "Yes, I want this, this is my carer, this is the person," you know, "Treat them as me," in the sense of the information flows and so on, versus the other situation? Particularly when consumers are often vulnerable.

MS CHILDS: Yes. So I would say when there is a first contact with a consumer, say within a clinical service, ask them if they have a carer or family member that looks after them or supports them, or works with them; if they say, "No, I don't want anybody involved," at that stage, ask again the next day. Keep asking that question, because that then allows them the consumer to have the ability to decide if they want family or carers involved. Don't ask once and then not ask, and if it's an outright no, don't ask again.

Also, from a carer's perspective, you don't have to talk about that particular consumer or that particular patient; it can be generic, it can be around you know, "Well, here's some information around Borderline Personality. Here's some information about services that may help you in this situation."

PROF KING: Yes.

MS CHILDS: There is some really good education courses that carers can be directed to as well, so it doesn't need to necessarily be an either/or; it can be, "Okay, this is where the consumer is at today." And I do understand from a carer role: a person that I care for on some days would be more than happy for me to have every bit of information, and want me to have every bit of information; on other days, they won't. But you need to keep asking that question, and that's where these standards within the practice come.

PROF KING: So keep asking that question on both sides?

MS CHILDS: Yes.

PROF KING: So it may be the situation, you know, you've said you want to share your information with this person, do you want this - and they have the right to say no?

MS CHILDS: They have the right to say no. It needs to be understanding on both sides as well. Yes, from a carer point of view there's generic information that you can find out. I do think though when people are being discharged from hospital it is fair enough to have a good understanding of what is expected of you within that caring role, and by utilising the triangle of care and having that three way communication, so it's not communication between the carer and the consumer and then the consumer and the clinician, it's actually let's all talk together. Providing that both - all parties are happy to do that that would be the recommendation that we found the best.

PROF KING: One of the things to in a sense enable that what we have been thinking about, and it's not in the draft report, so it's not obviously draft report as a point in time, we're still thinking and our thinking has progressed since the draft report, but it does relate to consumers and particularly the clinical data but not just the clinical data, and making it quite explicit that the consumers have rights over that data and can share that data. Do you think that would go part of a way to helping both empower the consumers and keep the carers in a loop in a sense rather than it being the case of, well the carer has to hope the clinician has a chat with them and invites them in afterwards. No, no, it's the consumer who says this person gets - 'When I'm given a script this person needs to be notified of exactly what the script is, the medicine and so on, that's my health data.' So we're sort of trying to think about how to make those lines of communication clear and consumer centred.

MS CHILDS: Yes. I think it's an interesting dynamic and it does - I think we need to - you know, we acknowledge it changes.

PROF KING: It does change, yes.

MS CHILDS: So asking that question on an ongoing basis, and trying to - I think it is - it is about good communication, and at the start of a discussion or when intake forms are being filled in it could be as simple as, 'Do you have a carer? 'No, I don't want anybody to know.' 'Do you have anybody that you deal with on a daily basis that we could have their name and address?' And then the next day it can be, you know, 'Yesterday you said you don't have anyone that cares for you. Is there anybody that you would like to have this information that might be able to help?'

PROF KING: Yes. It may not be a carer, you may not think of them as a carer, but is there somebody who you would like to - who assists you with your medication for example.

MS CHILDS: Yes, or assists you in day to day, or is there somebody that you call regularly when you need help, something - yes.

PROF KING: And then what would you like to share with them.

MS CHILDS: Yes, what would you like to share, yes. I'm not saying it should be compulsory that everything is shared (indistinct), no.

PROF KING: No. But it is getting that dialogue and in getting that balance right. And I think it would take a bit to move (indistinct) consumer centred in our approach, but we want to make sure that we're not locking out other really important groups by saying the consumer centre - at the end it's about empowering consumer and the outcomes for the consumer, recognising that needs a network.

MS CHILDS: Yes, it does need a network and wraparound, yes.

PROF KING: Young carers are wanted. I'm going to ask a series of questions and then I will pass over to Julie and then I will check if An has any questions. Young carers: young carers really concern me. We didn't go into a lot of detail on young carers, and I will confess

that my immediate reaction is that - I can't put my finger on it and I don't think the teams have put their finger on it, but something seems wrong in the system where you're putting so much onus on a young person who themselves are very vulnerable, are trying to get their education, get their life in order, at the same time we're saying that person can be caring for say a parent. That really worries me, so I'd be very interested in your thoughts about young carers, because I don't think we have any recommendations explicitly to young carers. Should we? Are we missing something we can recommend there?

MS CHILDS: I think a recommendation within schools to identify young carers. So is there a child within your class who's coming in and falling asleep, is being disruptive, you know, and what is the reason behind that, because I'm well aware of 5 and 6 year old and 7 year old children who are getting up making mum a cup of tea and giving her medication. They're making sandwiches and getting themselves to school. Obviously that impacts on their day to day, but they don't know - what they don't know - they don't know that it's different.

PROF KING: That's right. For them this is normal.

MS CHILDS: Yes, but it's different from anybody else. So I think early identification within the NDIS and psychosocial support teams that we have every time a team member is going - we go in to do an intake process we identify who is around - you know, are the young children in the house, are other people, family members within the house, and look at are the needs - are the supports available for example. The early intervention program is about identifying children at risk and young carers do face a greater risk of developing their own mental health issue in the longer term.

PROF KING: I don't think I have asked this. I was about to say I should know the answer to this, but I'm not sure I should because I'm not sure whether it's been asked, but when a consumer identifies a carer and it is a child do they identify the carer - because I was thinking what you mentioned before where, okay, let's have that conversation, let's make sure the carers are identified, they're brought in the loop where the consumer wants them to be. I mean that also is a way of then saying now we have a record of who the carer is. It's a child who's attending this school. I am reluctant to say the school should be notified because it's really the consumer's data, but that situation you are dealing with a minor and I think, yes, the school needs to know. But is there any issue, do consumers identify young carers?

MS CHILDS: I think in the experience we've had personally, but also what I've seen through Arafmi and HelpingMinds particularly, carer identification is really difficult. I didn't realise I was a mental health carer until I started the role with Arafmi. Stigma - that's a whole other ballgame - but stigma, I was brought up with do not talk about mental - do not talk about this person, we don't talk about this person because you don't. So I think the issue is carer identification, and I think it's a really interesting thought around - and I don't have an answer, I need to think about this more - around do parents realise that their young person that they are - their child - - -

PROF KING: Helps them with their medication, gets the breakfast for the other kids.

MS CHILDS: That is actually a caring support role - you know, who's the parent, who's the child sort of roles. Yes.

PROF KING: You mentioned that mental health caring differs from other forms of caring, and we recognise that, but at the same time, and you will see from the discussion in our report we sort of - we want to make sure that we don't say, well, yes, there's mental health carers here and there's physical health carers here and there are elderly carers here and they need to be covered differently because of course for comorbidities there isn't that. I mean you could be all three of those.

MS CHILDS: Or more, yes.

PROF KING: So I was wondering how - when you're saying the mental health caring differs and that needs to be recognised - how would that actually be recognised in the practical supports, or is it the case - so what do you mean, where do you want the recognition?

MS CHILDS: I think for mental health carers it's the understanding that it can be episodic. So with an elderly parent it may be for a fixed period and then that caring role ends. With mental health it can be - you know, recovery is a journey. We've noticed a particular cycle of time. So it is an episodic, and it can be that you're on call 24 hours a day seven days a week for two or three weeks and then there can be nothing, and everything's good for months on end. So I think it's that ability that sometimes there may be a need for more supports and sometimes - but equally you can back off those supports as and when required. Yes.

PROF KING: So we're trying to address that particular episodic nature both in things like a disability support allowance, but also in carer payments and in the rules around the carer support. Do you think we've got that right or do we need to go further or have we not got it right?

MS CHILDS: No, no, I think - I mean I felt that it was covered, but we wanted to emphasise I guess that we agree, and as far as the workplace goes ensuring that there's flexibility around the caring role from experience and from others experience as well who have advocated to us the ability to have a job is actually a good - I hate to use the word respite, but it actually helps. It takes you away from that caring role, it gives you something else to focus on. You have that social interaction at work as well. So it gives you something else I think that - - -

PROF KING: Just as it's good for the person's mental health, social interaction and possible employment, it's good for the carer.

MS CHILDS: Yes, absolutely.

PROF KING: Sorry, just my last one before passing over to Julie and Ann. So we've got material in and recommendations relating to peer workers. I get the impression from your statements today that - you said there's a gap in the community sector workforce that we haven't really addressed. Can you go into more details again as to what recommendations would you want to see. So other than peer workers - so is it relating to training of community-based workforce, is it relating specifically to incentives in rural and regional areas? Where's the gap we haven't responded to? Because we thought we responded to the peer worker, but if we haven't - - -

MS CHILDS: I think from the peer work perspective you have. I think it's about as I said embedding collaboration within clinical and community managed services. In experience we find that works well. Definitely looking at how we can incentivise regional and remote and how that's funded. So within the NDIS there is no - it's incredibly difficult to fund, particularly the very remote if you've got one person, an individual, how does that work. And I think around - qualifications around what psychosocial support qualifications need to be. Should it be a Cert IV in mental health, should it be a Cert IV in peer work, should it be - you know, what level, having that ability to have some career progression as well, because people don't necessarily always want to just be the support worker, they might want to seek further education.

PROF KING: They need a career. Yes.

MS CHILDS: Yes, as everybody does. So, yes, I think definitely around peer work it's captured. It's just how the wider community managed employment could work, and we will reflect more on that in our submission for January too if that helps.

PROF KING: Thank you. Julie, over to you.

MS ABRAMSON: Yes, I'll have a go. An's got my questions, Stephen, if you have trouble hearing me. It's a bit hard to hear (indistinct). It was really regarding - - -

PROF KING: So are you able to hear, Julie. Hang on, one second, Julie. Is that okay for you or is that a bit muffled?

MS CHILDS: I can try. It's a bit muffled, but, yes, we can try.

PROF KING: Okay. Is it better then Julie if An just reads out your questions and then any that she has?

MS ABRAMSON: I think so, because if the participant can't hear me - - -

MS CHILDS: Yes, I can, but it's - - -

PROF KING: It is a bit crackly and noisy. Okay, thanks, Julie. So if you go back on mute and I will pass over to An and An can be Julie and An.

MS TRAN: So in regards to the justice system you had some points around that in your briefing notes.

MS CHILDS: Yes.

MS TRAN: Did you have any comments to make about that today?

MS CHILDS: So we have - I have some specific grassroots feedback about the justice system and the prevalence as we know of mental health issues within the justice system and we were thinking we would actually expand on that. Unfortunately one of the people that has

been providing information has actually had surgery so they've given me very brief - so I will need to expand on that further in the written submission, but there's concern that within the justice system if people don't attend the roll call to get their medication there's no follow up, and that doesn't help them within the general population, and how families and carers too within the justice system can be - you know, if they're outside of the prison system how they can support the person that they would normally care for as well.

MS TRAN: Okay. So you will elaborate on that?

MS CHILDS: We can elaborate on that further as well.

MS TRAN: That will be great. Then I just had a question around - you mentioned a relational lens.

MS CHILDS: Yes.

MS TRAN: Could you explain that a bit more and clarify what you mean by that when you say we need to look at workforce from - - -

MS CHILDS: A relational lens. Yes. So it's how - the way that we look at it is the collaboration and interactions of all the different services. So it's not sort of you have clinical - you might have clinical, you might have psychosocial, it's about having that relationship so everybody is across and has an understanding, accepting that it is a consumer and preferably carer system, but how everybody then works around that to identify the home, the job, the supports that are needed, financial.

MS TRAN: So the relationships between - - -

MS CHILDS: Everything, social determinants, yes.

MS TRAN: That makes sense. Thank you.

PROF KING: No, I think we've covered - thank you very much for that and we look forward to your further submissions.

MS CHILDS: Thank you. I gave that to An before, she has all the copies. So thank you very much. Thank you.

PROF KING: So, Julie, would it be better if we put the phone on the table with the speakers? Okay, yes, that sounds good. So I will just pop you over on the table. The next person Fiona Stewart from headspace.

MS STEWART: Hello.

PROF KING: Hi Fiona. If you could state your name and affiliation, both of which I have just said, but for the transcript, and then if you've got any opening comments.

MS STEWART: Yes, my name's Fiona Stewart and I'm the manager of headspace Geraldton, and I have a small opening comment, I think I've got a page of comments, but I quite like the question and answer format particularly.

PROF KING: Yes.

MS STEWART: And I don't have it nicely typed up because I was writing, and this suddenly became like a university assignment when I read the entire draft report and really had a think about it and I'll definitely work on a submission as a result of that.

PROF KING: That would be brilliant.

MS STEWART: Yes. So I'm representing, what I think I'm representing is youth mental health in our region, and a rural and remote regional context. And just a little tiny background because context is important, that I'm a mental health social worker and I've worked in Victoria, the Northern Territory and Western Australia primarily but not exclusively with young people in the areas of homelessness, school wellbeing, victims of crime, child protection and mental health, and my background is actually (indistinct) education, so it was an incredibly interesting tertiary education journey into mental health. Ultimately I definitely come from a holistic view of the person in regard to health and wellbeing, hence I work in headspace centre. I think first up before - - -

PROF KING: Julie now says she can't hear anything which is slightly - - -

MS STEWART: Well, that's lucky because that was just the intro about myself. Hello to everyone I sort of vaguely know in the room. You'll be all going right, and Jamie will be going 'Ha'.

PROF KING: I will pop you formally back on speaker, Julie, because that may also have an effect.

MS ABRAMSON: Yes. I couldn't hear - I couldn't hear anything, Stephen.

PROF KING: That's all right.

MS STEWART: Hi. Can you hear now?

MS ABRAMSON: Yes. Yes.

PROF KING: Okay. It must be something about going on speaker, it expects the person to be further away.

MS STEWART: Just a summation, a mental health social worker who's been around the traps. So the thing that I wanted to - - -

MS ABRAMSON: Thank you.

MS STEWART: It's okay. So I'm old enough to be experienced and informed about some things, know a lot about - a little bit about a lot of stuff and some things well. I think the stuff I just wanted to comment that national rural and remote strategy I feel really needs to be developed that addresses issues around system challenges and delivering and enabling access to mental health information support and services.

I think of Geraldton - I've lived and worked in completely remote Aboriginal and Torres Strait Islander communities. I've been educated in inner Melbourne. I've worked in regional Victoria, New South Wales and Western Australia, and context like Geraldton, a remote regional centre auspices in a vast sparsely populated area, and there are specific community expectations and issues when you begin to break places up, especially in a massive state like Western Australia.

I think that high priority cohorts in regional areas, particularly Aboriginal and Torres Strait Islander people and young people and people who would identify as isolated, so that could perhaps be any person working in our primary resource sector, really need embedded in a reform acknowledgement around those contexts. Okay. And I was thinking after I'd finished reading this, or partway through, and this is not the place for it, but there's perhaps a philosophical question to ask as to where western - a society like ours is at in terms of this huge burden, what seems to be a huge burden of mental health need, but we're not in 101 philosophy, but there is something in the back of my mind that was just ticking over and over and over again. Some of it the report suggestions, no brainer, of course, yes, definitely. Others, are you kidding, or where's that at, or what's really going on here. So there was a huge overarching macro thing and I haven't quite articulated what that is and I'll probably need to go back and do an eighth year of university to do that.

So there's my little beginning. I was thinking that I actually read it and then looked at some of the reform areas and just have some comments to make under particular ones, but I'm really happy to be questioned on those if something comes up that you think, okay, she's done reform area one, that's what she's thinking, I've actually got this to ask, or you can go at the end, not sure.

Anyway, the biggest one that I had a lot to think about and connected it to some of the draft reforms was definitely under the reform area of prevention and early intervention for mental illness and suicide, and the very first thing I did write was obviously a proactive outreach needs professional and well trained people delivering that service, because I'm representing the context here. I'm not thinking about Perth and I'm not thinking about east coast, I'm thinking about this massive context here, and that the mental health of Australian young people under that reform is absolutely key to the nation's productivity and economic success.

Neuroscience is informing enough now, and it's written in the report around early onset, under 25 years of age, usually between the ages of 10 to 24. There's a developmental context in there. There's a real need for understanding the young brain and the developmental part - the developmental stages that a young person would be at between just that pre puberty to beyond before the consolidated brain.

Youth mental health is so starkly important, and I'm trained from 3 to 70. I could deliver mental health interventions across the age span, but fundamentally once a young person

begins to hit pre puberty to puberty you have an individual emerging, and the context of a child, and children were spoken about a lot in the report, of course, as early intervention as you can get. Then there was a lot of the acute system and I really felt that in there the youth mental health understood as a model and the neuroscience informing it was not actually apparent, and in actual fact I felt that the value of what - you can call it headspace or a model like headspace gives to that age range was actually not understood. I didn't read what my headspace does in the recommendations, and obviously recommendation 24. - whichever one it is - what was your final one, 24. - it doesn't matter. Anyway I'll keep going.

So in this one I just needed to really represent what the potential is for that. So we have - I think it's really important the utilisation neuroscience informs around the onset of mental illness and therefore the type of program delivery that you do. That is really crucial, and if not absolutely the decades of impact on a human being, or where in a Productivity Commission the economy, it's a no brainer. I know it's hard to figure out what that cost is, but if young people are not maintained on their trajectory through school, supported and family supported, well, we've just got decades of taxpayer funded support, but more importantly you've got people who aren't leading lives the best life that they could possibly lead.

The report seems to miss, as I said before the strength of a headspace model and service, especially around the localisation of headspace centres and how embedded they are in their communities. So for instance with headspace Geraldton I completely feel that we've got the flexibility to adapt to local needs and presentations to a degree that no other clinical service I've ever worked in has.

In this headspace we actually miss a key part of the headspace model which is the private practitioners that wrap around it, and in this regional and remote context obviously that means we lack staff and that would be a great thing, but as a result we've got really creative in how we deliver a service, and I can be creative. I'm not bureaucratically restrained in that and I think that's absolutely amazing, and for instance we've got a series of partnerships with a variety of NGOs on a needs based basis. What do we see, what are the themes, and literally can flexibly turn next week if there's themes that need to be addressed for young people and their families, and a key thing for us is their families.

We have got partnerships with private organisations that have been trialled this year and are going into next year which I think is remarkable, and two examples of that are the Port Authority here in Geraldton fund raises for its headspace, and says to us with the money that it's given us recently, 'We want to support you to trial intervention services' - I've targeted juvenile justice for young people - 'and here's some money that we know you don't have in your budget to pay for fuel and vehicles to give clinical intervention to young juvenile justice fellas.'

Also a national conservation organisation has come on board for us in this region, in the mid west. We're trialling with Bush Heritage Australia using the land that they own to take young people onto it in long format. Bush adventure therapy is what we're just trialling for a cohort of young people. That's a private partnership.

We have got placement of staff in schools for priority groups. We assess our data, where are the young people, vulnerable people, who cannot get to our headspace, our bricks and mortar headspace, we're funded, no bells and whistles headspace. So primarily in our region we looked at Aboriginal and Torres Strait Islander young people, particularly male young people and said how do we get to places where we can offer services to them, and currently - I got our happy results today, our data off today, and we are sitting at 29 per cent of our clientele is Aboriginal and Torres Strait Islander young people for what is a mainstream service essentially, but what it says is we've got the flexibility to say what does our community need, this is what we need to do, and how we have done that is being able to put staff in places where young people are and creating models of intervention - not assessment - I'm not using words like that - ways of hearing what they need.

I have three staff working with Year 7, 8 and 9 Clontarf Academy, which if you're not from WA is an Aboriginal and Torres Strait Islander young male engagement in schools program. One of those staff has been with the same boys for two years, and he'll be in Year 9 with those boys and he'll go through and graduate. And the staff had a meeting with me this week, who said, 'We're beginning to see the benefit of that imbedding.'

Over time, the boys now approach that staff person and they ask for one-on-one conversations with him and they're coming to the bricks and mortar headspace which is, like, extraordinary, but it took time and commitment out of one-on-one clinical time within a headspace to say, 'That priority group needs something really different to get to know us and to get to know how we work and we need to get to know them and understand who they are and where they're at.'

We've been delivering an outpost service delivery model in the mid-West to a couple of sites to see how it goes from a clinical perspective which essentially means we go out to a couple of schools that were saying, 'We're desperately in need of help, please,' and set up our clinical model and community engagement model on those sites for very, very vulnerable young people who were never going to get into town.

And what this does is provide multiple access points and multiple ways of supporting young people and the model that I work under enables us to do this because I have the auspice as the manager to look at the data, to make sure I justify our spending within the context of our contractual agreement, but to say, 'This is what our community needs,' and do it and our statistics around LGBTQI+ and Aboriginal and Torres Strait Islander young people are huge for a regional area and I think that's a flexibility as Geraldton's headspace and the community recognises, and the community recognises at Geraldton's headspace.

Just the one key pathway that I think is really important in terms of for friends and family and particularly for vulnerable young people is we created what we call is 'got a lot going on', and got a lot going on is essentially no wrong door; if a young person walks into our headspace within the headspace priority groups, which in our region are all young males, Aboriginal and Torres Strait Islander young fold and culturally and linguistically diverse. You can identify sometimes those young people.

There's no intake process; there's no 'can we re-book you in?'; we've created a special pathway that the attitude of the staff is 'we see that person now.' No case write noting is more

important than seeing a young person and families come in, and grandmothers and parents and particularly for our Aboriginal and Torres Strait Islander young folks, they are heard there and then where they're at because help seeking for all young people is situational and timed and asking a young person to come back in three weeks because, actually, our intake is full and we've got a week wait list is not okay for vulnerable young priority groups, and I feel that headspace Geraldton has done the best it possibly can because we've been given the flexibility to do that.

So that's in the acknowledgement that I understand that the commission is looking at prevention and early intervention and it's key; it's absolutely key with that embedded word of flexibility, wrapping it around.

Program creation for young people in terms of - I mean I mentioned bush adventure therapy for juvenile justice, young people in our community, but also friends and family embedded practice and as an example offering absolutely regular family information services on a weekly or bi-weekly, you know, opportunities. Information sessions, single session family consultation is so important to the care of our young people and they are able to identify who they would like as part of that, and we ask every single young person, 12 to 25 years of age, 'What name would you like us to put down here?' and this is the type of information in terms of psycho-ed we share with them, not the young person's story, I'm talking right at the front end of practice, and families can book in with our clinicians on any basis that they want to talk about where they're at, and the conversation is clearly had with young people around what that means for them in terms of confidentiality also.

The only other comment I wanted to make under the reform area was under the senior teacher emphasis, and I was suppose a little bit confused by that to a degree. The best practice that I've worked in in terms of well-being in schools was in Victoria where I was a mental health social worker, I was the well-being person. So a principal hired me and put me in there and the sense of that - I'm not teacher trained. I sat in an office and was experienced - social workers are - the teacher thing was interesting because I feel for education where the burden of psycho-education and the emphasis on change being placed into teachers and upskilling teachers were, to a certain point, What's their core business? and then, What's their expertise? And when does it just get too overwhelming for them.

It is an absolutely no-brainer to me to have people who are trained in expert - around how systems work. So I'm not talking family therapy in schools, I'm talking systems work, and I think though, maybe that's more a comment than anything else that it just made no sense to me about labelling 'lead teacher' 'senior teacher' rather than - there are people who are trained to do this, who could be employed by education to sit in a role that means their practice is very flexible and they're completely across how to work with families.

They know what their community's referral systems are, what resources are available, why wouldn't you use that workforce instead of the teacher one - the lead teacher concept or senior teacher concept - and then creating - it occurred to me also in there that sort of what, perhaps, consumers and families are asking is a type of headspacey sort of model for very, very young people which is, you know, that primary school parents and teachers can access, that is totally around family support and an early identification and looking at young people who come in from marginalised backgrounds and putting that support in very, very early obviously makes

sense to me. Headspace is an early intervention if it starts at age 12, but what our headspace model is a youth model beginning at age 12 is looking at a neuroscience perspective of brain development; and that's all I had to say about that one and that's my longest one.

PROF KING: All right.

MS STEWART: The critical gaps; of course alternatives to Ed's are really important and creative partnerships would have to be formed to make - when I looked at the reform dot points, what was being commented on, and I think from a perspective here, it would require a dramatic practice shift from state mental health systems. Not people who work in state mental health and not intent and heartfelt and internal motivational capacity, but rather systems trying to work together.

Experiencing, you know, a funded NGO headspace, trying to work with a state system, is actually incredibly difficult at this point and I think that that's going to require a dramatic practice shift from bottom up and top down, and in a region like this, it just makes sense to me that something like - and I don't know if (indistinct words) is the latest way of describing anything, but for acute care strategically placed and based, particularly for young people and Aboriginal and Torres Strait Islander young people so that they don't have to leave their regions, ever, under an acute care setting is a huge gap where we are.

And it occurred to me that I don't know how creative the commission gets to be to how it looks at what complete change is because I'm for rebuild the system personally - rebuild the system. But have you looked at the Trieste model after deinstitutionalisation in Italy? In Geraldton, when I hear consumers and consumer advocates speak about what they would like or when I hear adults come into the headspace door and say, 'I wish there was a service that looked like this for me,' and it's because it's got great couches and cushions and a dog, and a whole lot of really wonderful stuff going on and it's purposefully fit out like that.

But the 24/7 short-term care doesn't make sense in that Italian model. It seems to be that a region like - you know, and that model is based on populations of 50,000 - it just seems to make sense to me that that's the sort of stuff that I hear consumers and adults particularly, talking about young people are keen as mustard to come into headspaces but their carers and also adults who walk into headspace and say, 'I was told this would be a good place to come but they're out of our age range.'

Number 3; the investment in services beyond health (indistinct) housing. All I can say is, 'Of course,' and it's a huge issue for young people in our region. 'There's a wonderful housing organisation and it's chockers,' and there's not really an interaction with the state government housing very well I do not think, particularly for young people.

And number 4; the work, and obviously, the IPS' are known to be attached to some headspaces and those headspaces are seeing great outcomes; we have nothing here at all and it's a huge gap. We have a vocational person but we don't have a program and this goes back to my original comment about regional and remote specialist embedded situational stuff within the reform package and under care coordination and governance, the one thing that stood out to me was the single care plans which could be an amazing thing and it would

really need some mechanism of making that happen that where state and regionally funded services comes together on that.

It just feels like bureaucratic nightmare to overcome but could so simply be utilised. Like, this makes complete sense to me but in order to do that, it would take time and funding to, from a practice perspective, pull that off well. To look at that caring coordination with a whole lot of services, particularly from a clinical perspective that could be working with a young person, which we try to do, it takes time and time, it needs funding because some people look at KPIs. I don't particularly necessarily, but I know that that is really important; and that's it.

PROF KING: So a few questions that I've got coming out of that. Thank you very much. So headspace is a very interesting model and our recommendations relating to headspace basically say, 'Well, as with every program, it needs to be evaluated and it has to be making sure it's meeting regional need,' and from your comments, it certainly seems to be meeting regional needs here in Geraldton. But we don't get a consistent story around Australia and so I'd be very interested in you commenting on how you've found the headspace model, because it is a franchise model.

We've certainly had conversations that say, 'The benefits of that is that it maintains' - I can't remember what the clinical term is but, you know - - -

MS STEWART: We're (indistinct) governance and - - -

PROF KING: No, but lately on the clinical side as they say or it sort of maintains integrity of the model which seems to suggest a lack of flexibility and we've heard from some others that, perhaps, in their regions that the headspace model, perhaps, doesn't have the sort of flexibility that you're talking about and I can't judge whether it's meeting regional need, which is why we recommend, 'Well, it needs to be evaluated,' and then it has to be up to a regional body to work out is headspace meeting a regional need.

So, I would like you to comment on that because your experience with headspace may be different to others but I really want to - have you talked with other headspaces?

MS STEWART: Yes.

PROF KING: Do you find that the franchise model limits you at all or is it really - I mean you painted a very good picture.

MS STEWART: Yes, well, I'm a graduate of the clinical assessment of Melbourne Uni and the model came out of that to a degree. Totally; and I know it's not even a gut inclination answer it's - I think about these sort of things all the time. It's the lead agency; it's a very strange model and I can guarantee you that flexibility - because the model, remember, has a lead agency and the lead agencies are all different.

PROF KING: Yes.

MS STEWART: And I very much think that that probably could answer some of your questions around how do some headspaces seem to do some things and others not and the lead agency - so essentially, when you're a manager, you have you have a PHN person you report to, a lead agency operations manager and you have headspace National, all three asking you to do things at any given time.

It's a strange model of governance and contracting. So if you're lead agency manages you well, and I feel like our lead agency obviously does that because all of the things that I've described - I do know some other headspaces are sort of like, 'How did you manage to pull that off?' You always have to have fidelity to the clinical model. I'm a clinical person.

PROF KING: That's what I was after; fidelity. Thank you.

MS STEWART: Yes, but that's because you are informed by neuroscience.

PROF KING: Yes.

MS STEWART: I'm utterly and totally formed with the best practice that we can that's coming out of - and we're now moving into a whole lot of behavioural stuff with our really early intervention young people and - anyway, no, won't go into that. That would just take us off somewhere else.

That makes sense to me. It's the lead agency context I think is what can really vary what can go on for headspaces and whether they get the resources they need or not or the flexibility to deliver. So Broome headspace has a fleet of four-wheel drives out the back 'cause it's lead agency is the Kimberley Medical Centre and they get that you go bush. They get that; we're our young people.

PROF KING: Yes.

MS STEWART: So I think that answers part of that question.

PROF KING: So we've heard criticism that, you know, headspace is very unusual at the moment in the sense that whilst some money comes through the PHNs, it is directed money. So the local PHN's are - and obviously 'local' has different meaning depending on the different states because they have different number of PHNs, but let's say the local PHN doesn't have discretion over those funds, and we've heard from both sides. So we recommended that over time, that it should be - whatever the local funding authority and we've got options there - but whatever the local funding authority is, it should be deciding whether the headspace is the appropriate way to deliver services in its region or not and, you know, some people have said, 'Yes', and some people have understandably said, 'No, that would be terrible. That would undermine all the gains that headspace have done.' What's your view on that?

MS STEWART: Would you like to hear my summary? Because that's exactly what was in my end statement.

PROF KING: All right, please, yes.

MS STEWART: Okay, in my summary I just said, 'Staff bleed green,' and I make no apologies for that because we work in a service model that, although not perfect, is the envy of the world in youth mental health delivery. It's a national, flexible, clinical model and it is a flexible, clinical model, it really is; that delivers to communities and engages young people at critical developmental times. It's informed by latest neuroscience and is and can be creative and flexible.

The 24.2 draft recommendation that we're talking about at the moment, I've written here 'that PHN's not funding headspace centres'. I mean you compare (indistinct) it could be the new model that you were talking about when you collapse it altogether and it's re-pulled out - sorry, Amy.

PROF KING: Whoever the commissioning bodies are.

MS STEWART: Yes, whoever it is.

PROF KING: Yes.

MS STEWART: We're a small population in Australia. You know, we're New York city and an entire huge nation and some of this is like, 'How are we not getting this right?' is that it really would be the beginning in the end if you pass that through because what happens to a place in regional - when there is a model that you can look at that passes clinical expertise, has a whole lot of other engagement arms to it, absolutely embeds friends and family practice, is out in the community and is known and is accountable to mental health commission frameworks and is accountable to chief psychiatrists and can be audited on any given day, I don't know who Amy would actually turn around and get in to replace that and eroding that national network it would also erode consistency because there is a level of - so when I say, 'Staff bleed green.'

I've got an allied health team there who are made up of nurses, master's in counselling, mental health social workers and clinical psychologists at the moment, and all of them have worked in diverse mental health arenas and they literally bleed green, now, to the lead agency sadness because they're not green; they're a different colour. Yes, so I think it would erode the consistency in standards that community and parents have some expectation around.

PROF KING: Okay.

MS STEWART: Remembering that in a region like this, we have an early intervention headspace which is - which takes on clientele far above, even though we've been asked perhaps not to - what our funding auspice is, and you have a very busy state system and that missing middle is definitely an issue here, because there's not a service provider for that missing middle.

PROF KING: So again, just - should be a question coming through. Just to push a bit further on that though. Given that headspace is so good for this region, wouldn't anybody looking at regional commissioning say, well yes, headspace continues, there's the money for it, and we now need - you know, we've got other money for the missing services that need to

be provided for. So I just find it odd that everybody says we want regional solutions, but the one program, and there is only one real program in psychosocial support in the mental health space, perhaps is a better way of putting it, that is, it will be run, is headspace.

There is that direction from the centre which seems to be completely against that, well, you have a regional governance model for what is needed on the ground in the regions, it's a very, very, centrally controlled funding process and I just find - and the defence is, but headspace is doing a great job, so surely we've got to keep funding it. My response is, well headspace is doing a great job, so they will get funding from the regional funders where they are doing a great job.

I'm really struggling with this. We want regional, but we love the central - the centre has said, these will be funded. It's not a regional - headspace is not a regional funding model. It's a centrally drive Commonwealth - - -

MS STEWART: No, but your practice is.

PROF KING: I understand that.

MS STEWART: And that's what counts for people.

PROF KING: Yes.

MS STEWART: And so, I really think the lead agency is your question there, and that's perhaps then a PHN responsibility to look at lead agencies and make sure that they're allowing the headspaces that they have gone out to tender for - you know, are they an agency in the region that's been tendered for, so you understand your region. That could be questioned. Or is there a flexibility. Do you hire managers and clinical leads that are qualified and skilled enough for you to let off the rein to do what they need to do in their region? They're the sort of questions that I would asking of PHN around the lead agency.

PROF KING: Okay. So I'm really going to push this, because it's a - it is - I think it's really important. Let's say we take the - and I'm picking on the Kimberley for any particular reason; headspace services up there are fantastic. Kimberley, very large Indigenous population. We've heard from many Indigenous representatives that they feel Indigenous controlled organisations are a key to improving mental health in Aboriginal and Torres Strait Islander peoples.

So again, let's say we go to a - went to a regional model and they said, well, Kimberley headspace is fine, but it's actually not meeting the need because it's not Indigenous controlled. So we're going to defund headspace, but we're going to have Indigenous - because we need those funds for more of the Indigenous controlled services, and we make that decision on a clinical basis at a regional level. What's wrong with that decision? Because under the central headspace model, you're saying that decision cannot be made. That decision is ruled out centrally.

MS STEWART: I don't think I'm saying that, and most of that makes sense. But what you're asking for - and also, I think, you know, you can put - you need to be able to pull back and have a look at what the determinants are as to why - and poverty is a key one here.

PROF KING: Yes.

MS STEWART: Poverty is an absolute key to the ill-health of young people in the Kimberley.

PROF KING: Yes.

MS STEWART: It's the one common factor across all of it, and no headspace is going to change that. No headspace can deal with it.

PROF KING: Yes. Poverty, trauma.

MS STEWART: Poverty. Exactly.

PROF KING: There's a whole range - - -

MS STEWART: No, no, not trauma. I'm using the word 'poverty' specifically. Headspace is working - can work in trauma, but they can't - they're not the mechanisms of government to be able to deal with poverty, and intergenerational poverty, and their health determinants that come from that, there's a piece in there that you can work in. An expanded workforce that works collaboratively, or works side-by-side, is possible.

I mean, our headspace has 29 per cent, as I said before, of young people, and that's those young people who want to come in there. If there was another equally robust service that they could access, maybe they would too. Or maybe they wouldn't. Lots of young people come into headspace because it's not related to people that they know. Twenty-nine per cent comes from people accessing it. They're making a choice.

PROF KING: Yes, all right. Sorry, I'll just quickly see. That one. I've done that one, I've done - all right.

MS ABRAMSON: (Indistinct).

PROF KING: All right. Sorry, Julie. Yes, I'll let An ask your questions, I think. I've done all mine. Sorry. An.

MS TRAN: We can get some questions - - -

MS ABRAMSON: I think what we might do (indistinct) to have - we could take my questions on notice. I just wanted to know more about the (indistinct) aspect (indistinct). Happy to receive that in a submission or just in email form, and then the other issue was related. How does the (indistinct) community - how do they get to the services? Like, what's their outreach program that brings people in. But happy to have those on notice.

PROF KING: Are you happy to take them on notice?

MS STEWART: Yes.

PROF KING: Because yes, I have completely blown the time (indistinct).

MS STEWART: Yes, yes.

PROF KING: And An, did you have any other questions? No, all right. Thank you very much.

MS STEWART: That's okay.

PROF KING: Thanks, Ms Stewart.

MS STEWART: Thank you.

PROF KING: I've now blown our morning tea time. But can I suggest we still take a morning tea time. Perhaps 10 minutes. If we can come back in here about 11.07. Very specific. All right, 11.10. I suddenly realised I hadn't changed - - -

MS ABRAMSON: Sorry, Stephen. I'm sorry, Stephen, I didn't hear. When are we reconvening?

PROF KING: So, we'll do it at 11.10.

MS ABRAMSON: Okay. Thanks, Stephen.

SHORT ADJOURNMENT

PROF KING: Okay. You're fine? Yes. Let's start again. So, Clare, if you could state your full name and organisation, and make any opening comments that you would like.

MS GREEN: Great. So, hello everyone. My name is Claire Green. I'm from Elucidate (indistinct). For those of you who don't know, it's a funny word, but it basically just means to make things clear, a bit like illuminate. So I have worked in multiple sectors, including the private sector, the public sector, and the not-for-profit, or community managed, as we now call it, sectors. And so my role within Elucidate as business owner is basically just to consult on various programs, projects and modelling, as well as professional development training for staff.

So in particular, the areas of trauma informed care, as well as protecting the workforce for burnout and fatigue and vicarious trauma, which is quite prevalent within our workforce. So my comments today, as opposed to relating to a particular program, or organisational agenda as such, is more just to see and comment on the sector-wide issues, which is what I'm quite passionate about, is that leadership and innovation within services.

So my comments are really just broad comments around some of the recommendations that I've seen as I've worked with a lot of different parties on the ground, including consumers and families, as well as organisations. So I'm just giving you some broad detail today. So, all good to start then, with the formal - - -

PROF KING: Please.

MS GREEN: Okay. So, the first thing I wanted to do is start off with the IPS model, which I'd like to say that in theory is a really sound model in that you are utilising an employment consultant with the community mental health service. But I do note that sometimes it's been a bit hit and miss in terms of the consistency that has occurred on the ground level, and partly I think that is because in the sort of employment agency (indistinct) organisations, I was working as an employment consultant many years ago, before the star ratings came on board.

And we could be a lot more flexible in terms of who we worked with, how we worked with them, and could be a lot more holistic. When the star ratings come out, it forced employment agencies to be very efficient and driven solely by KPIs, and I think where the IPS model can sometimes fall down is if a particular employment organisation actually has a contract, but then suddenly the star ratings aren't that great, or have decreased, they're at risk of losing their funding, which means that IPS consultant who's based in that employment agency, you're going to lose that IPS consultant because they're going to lose their job, or they're going to have to be reallocated to a different location.

I understand that would probably work quite different regionally than in Perth metro, but that's just my understanding and experience so far. So I agree with some of the recommendations in the draft report about maybe looking at employing an IPS consultant directly in the community mental health services so that we get some consistency, and also to that, employment providers in general are not necessarily biased.

So, for example, the way I see it working in a positive model would be that the IPS consultant is embedded in the community mental health service, paid a wage by the community mental health service to continue consistency, but then linked with a lot of different employment providers, which could be the consumers choice. It could be the choice of the community mental health service. It might already have some great partnerships and collaboration going already, but it would just sort of link in that consistency.

Also, to get specifics, because I'm also really interested in the practical level of service delivery, is that I would also arguably say that the IPS consultant needs to be paid, obviously not a clinician wage, but a higher wage than a typical employment consultant would in an agency setting. Simply because the complexity and acuity that you get in the caseloads of community mental health can be quite high, or higher than a Aboriginal employment agency.

And also, because you are working within a multidisciplinary team, which in a clinical model is actually quite specific and has a lot nuances that are quite - can be quite different than other multidisciplinary teams in, say, a not-for-profit sector. So I would suggest that they do actually get - that when things can be initiated, they are actually recognised for their expertise

in that area, and employed as a specialist as opposed to your average consultant. So, is that okay if I just keep going through my points?

PROF KING: Please. Yes, yes.

MS GREEN: Or do you want to stop me at any time?

PROF KING: Yes.

MS GREEN: Okay. No worries.

PROF KING: We'll have a bit of a discussion about these.

MS GREEN: Okay, great. So the next one is on - just a brief mention on the non-legal advocacy services. So while I recognise it might be different for different bodies in different states, and maybe some different platform services, my - I'm still getting consumers and carers and families not actually knowing that there are actually advocacy bodies available, and I'm not talking about sort of Legal Aid or your mental health law centre kind of advocacy. I'm just talking about your general advocacy services.

So I think it's really important that we make these services explicit. I think, as workers and the staff and managers within organisations, we're quite aware. We network quite sort of widely, I guess, to say, in terms of knowing what networks are out there. That's sort of our job. But it's not really a family's role or a consumer's role when they're unwell or not feeling great, to suddenly try to network and work out where an advocacy service may or may not lie, and how to deal or don't contact them.

Especially if families are overwhelmed and stressed, and consumers are overwhelmed and stressed, typical communication and phone contact and face-to-face meetings can be quite difficult at those stages. And I also believe that we do the mandatory note of telling people their rights and their responsibilities, and we might even give a great little informational share pack, but if someone is feeling unwell or overwhelmed where that family member is really concerned, you're not necessarily going to go to the brochure in your pack to work out what's happening.

And as individuals in this room, we don't have brochures in our back pockets to say, that's right, I need this emergency service. That's just not how the average person works. And so we need to treat mental health people, like the Aboriginal person, in that we need to make sure that information is explicit. So I think it needs to be mentioned in ED departments, in inpatient facilities. I think that at the community service level, we're a lot better at that, but I think, in those critical moments, we need it to be explicitly mentioned.

But I would also go further and suggest visual displays. If we had a wonderful visual, and there's no reason why an amazing graphic designer couldn't work with - excuse me - you know, someone from the health department. And I say graphic designer, because it has to be eye catching, like the person wants to make a phone call, not another government document.

That it is actually visual and eye-catching on the wall, and it's actually placed there. So okay, you know, if I was to be a consumer a family in my first day of care, I might be too overwhelmed to call an advocacy body; but if in my fifth day, and I see something eye-catching on the wall and I think, "Yeah, actually, I really would like to talk to someone outside of this service. I know exactly where to go and it wasn't in my tenth document in my information pack on day one when I've lost it already on day five."

So I just want to be really practical in that regard, because I think there are lots of little changes we can make at the real practical service-delivery model level, that doesn't include a mass amount of funding on just information and communication.

The other idea that's already talked about today, and I just want to put a slight addition to it - I won't go on for a long time - is the idea of social and emotional learning programs in the education system. I, very like Fiona, sort of started way back in education and then weaved around eventually to mental health, so I've been a teacher before and I know what that's like.

My question, which might be now out of date, I'm not quite sure, but why aren't we utilising school psychologists? Because I know - and I've still got friends that are teachers currently - that they are at the forefront of seeing when intervention should occur, they know when little Johnny for example, is quite different from the other 29 kids in the classroom, or the 25 or whatever states cap their numbers at. But the help for the teacher to then get assistance or referral pathways or networks for that little Johnny can be very time-consuming, and often takes more than the school year, if it's a complicated case.

I know sometimes school psychologists can actually be - and again, this might be just the metro area - spread across multiple schools, so I'm just wondering where - and maybe you can let me know later on, or whenever - what are we doing about that and is that something that the Productivity Commission thinks is going to be phased out, or is it something that we can support and actually you know, resource and fund to actually come in and do that early intervention stage? So just in addition to what's already been said.

And the other thing that might be a little bit controversial: you had some recommendations in the report in terms of improving training for doctors, and with doctors I took that as GPs and psychiatrists. And I guess what I'm asking is that we already know sometimes that GPs struggle because we really only have community mental health service, emergency department and GPs, so if you're not in the other two you're probably going to go GP. And we always tell people, "Just go to your GP, you'll get some support."

But we know that GPs - not all of them, but some - are saying that their allotted time appointments in terms of creating mental health plans and care plans is quite short, and they don't feel like they've got enough time. Sometimes it can be quite overwhelming for them to navigate the different referrals and support services they can add into that plan, and linking to, as well as just being able to have the confidence and experience to address that kind of niche area that might not be their every day-to-day kind of work.

I do recognise that I think the regional areas probably do this a lot better than the Perth metro areas, in that everyone in the regions know the regions, which is great. And I think the Perth

metro area can learn a lot from regions. So just to be transparent, I am from Perth metro but I do regional workshops; I am very interested in this meeting.

So I guess what I'm saying is that there is so much siloed effective services, and I'd imagine there's even that between the regions, so what Geraldton and the Kimberley do will be completely different, as opposed to what Perth metro does. So my point is not just on adding more specific training around professional development points or you know, accreditation or things like that through AMA, but what are we actually doing to train them up on the ground, day-to-day, face-to-face kind of training that we need?

The other thing I guess that I wanted to say is that I always hear a lot of talk about medication and I am for medication; when that happens in a beneficial way for someone, it can radically change their life. But if we are only talking about training in administering, recognising, you know, prescribing medication or treating diagnoses, I feel like we're missing a key training component, which is in recovery-orientated services, trauma-informed care, which actually directly results in how someone presents.

So you can try and go to diagnostic criteria and hope that you get it right, but a lot of people said determinants this morning, and I feel that the training for doctors and psychiatrists actually needs to be around some of those determinants, as opposed to the sole clinical/medical model of brain and body.

I totally know that brain and body is the main thing that they are qualified in, but I just wish that we could maybe add a different level of training that would maybe help them feel more confident in their day-to-day communications with people coming in, because I think that's really important; even things like co-production planning for services programs; even how to actually do a care plan with someone and actually make sure that that communication dialogue is equal and really beneficial for both parties; training on that actual practical element of, "How do we do this well, and how do doctors actually feel really confident in doing it well?"

I feel like that's something that gets missed out of the formal professional training suite that we make people do. So just as again, very practical. And also, another thing - and Fiona mentioned research from Italy which I think is great - because the other idea with training is that we're not just making sure that people doing evidence-based practice in their day-to-day, but what are we globally looking at, what are we globally researching? So for example, in other countries there are people with schizophrenia that can work full-time and they have high success rates; over here, if you've got schizophrenia, you're lucky if you ever work again, and people will tell you that, unless you're a recovery-orientated clinician or professional, and then there's much more hope.

So what I guess I'm saying is, how can we make sure that training aligns with relevance and currency, and not just a textbook model of training and qualification, and how do we do that? And does that then relate to the tertiary institutions having KPIs on their training and how they can actually maintain relevance and currency on what people are studying?

Because if we're studying the same thing now, in 20 years, well, then we've got something wrong; if we're studying the same thing now, in even a year or two, we're probably not

moving with what's happening. So we can add additional training once they're in the sector and they are working, but how about we start right with the tertiary institutions first, and keep them accountable because they do get paid a lot of money to teach.

So then I guess what's also been talked about in terms of the guarantee of psychosocial supports; this is a big one for me because I have a lot of networks in the not-for-profit sector. I do believe and agree with the submission so far - sorry, the draft report so far - that it is optimal that the contracts be extended for psychosocial ports. And that additional measures should be considered to support those who have not been eligible or not want to apply for NDIS, through that national psychosocial support measure.

But I really want to note - and I can't stress enough, because I am very aware that I represent lots of different roles and lots of voices - that funding for such contracts needs to be funded enough. So what I am hearing on the ground from a lot of different not-for-profits - and this isn't breaking confidentiality, this is just sector-wide issues I'm talking about - is that they are worried about their business model, and they're worried that the funding for such other models, the psychosocial support that's not in NDIS, post this year measure, that it won't be enough money to cover things like vehicles, to cover the one-on-one kind of work.

And a lot of places are talking about you know, group activities instead. And I would hate that the funding for such psychosocial supports is so short-changed or reduced because we think NDIS is the answer, that the people that fall through the IPS actually are left with very minimal funding, and you've got services and workers that don't know how they actually provide the same level of care and support, in a different model.

So my comment would be that we make sure, or put some steps in there, to make sure that any psychosocial support models post-NDIS, post the national measure, is actually adequately funded and is not a substandard or subclass of the NDIS, because that means that people actually are not getting the care, and they're actually disadvantaged by NDIS, rather than advantaged by it.

In saying that, I am all for NDIS when it works really well and for flexible, individualised, tailored funding; I just think we need to be careful of lumping mental health with disability, when there are a lot of people that don't believe disability and mental health are the same thing. People can be debilitated with mental health, but not necessarily disabled; that's just maybe a controversial opinion, though.

So yes, so just the point would be to make sure we adequately fund whatever moves forward, because people out there are a little bit scared of how they're going to fund their staff, of how are they going to lease the premises, how are they going to pay for their vehicles, and what programs they can come up with, with substantial reduced budgets.

Another point in terms of the wellbeing for leaders in schools - and it's already been talked about - what I will just add to is that we need to be careful that we don't add another one tokenistic person within a school, because I don't believe it's enough to create transformative changes. And I think when we do one of everything and just place it in the middle of a big context, that it puts a lot of pressure and strain on that person.

I also wonder, can we co-ordinate more services that are already existing on the ground a little bit better, in terms of we've got chaplaincies, we've got student services, we've got administration teams, we've got group programs; schools can also bring in youth programs that they feel would meet their needs. A great example is headspace here.

I'm wondering if we just need to collaborate a little bit more and work out something locally, or something like a clinical service or a not-for-service that's got that specialised arm that can actually do a better job than just trying to train-up one extra teacher. And also, it's very hard to retain teachers sometimes in the workforce; we've got an ageing workforce in teaching, so we need to be careful that we're not scaring them away by more pressure, which has already been talked about.

Then young adults and tertiary supports are linking their online services and resources. I think we can actually learn a lot from TAFE systems, because I think as much as the TAFE system does include a disability support adviser - and I don't really like that title - but they do have models to actually plan and get that person through that qualification; as opposed to a university that is generally quite a big system and if you're struggling, the stigma of saying that you're struggling can be harder, especially depending on what you're studying and if mental health would be a good option, or a really dangerous career move to admit to.

And I think we need to be very careful that we do actually plan that people can finish studying, because often it's not always a mental health crisis; sometimes, it can be a situational thing that happens. And we need to address that, and the stress and anxiety and trauma that might go through an incident or an event, as opposed to think that we're going to have to babysit someone for the whole of their degree. Short, little bursts of intervention can actually do a really good deal of help and assistance.

Also, then if we're talking about tertiary supports, we need to make sure that whoever is in a role or whatever kind of links to services happen, that they do know what their links and their referral pathways can be, that they do know what supports they can actually link into.

The other thing that I also would like to mention is something that is quite cost-effective; you were talking about links to online resources, end services. It's actually just making it, again, really practical, making it in the platforms that they're working with; so university today is all pretty much completely online; you've got blackboards and other platforms where everything is submitted, read, downloaded, viewed. Why don't we just have a link on there that says, "Look, are you stressed, overwhelmed, got any mental health issues or concerns? Click here for some support."

It could be as simple as just adding a little icon on a digital platform page that then has the reference to the number of support services, pathways, or even just to see the GP, as long as we support GPs enough. You know, there are little things that we can add on the day-to-day that doesn't have to be the big picture stuff; it can be at the localised level, just adding little communication aspects to make it easier for people to then get online help.

In terms of governance and evaluation, I realise that it's a little bit controversial, but I do like to be practical and also forward-thinking, and so my question is, what's going to be done to ensure that any new inter-jurisdictional statutory authority will remain and be sustained

through a bipartisan approach, to eliminate wastage of resources in completing reports that arguably don't amount to long-lasting change. And can this authority be objective and un-politicised for the good of its noble intentions?

As much as I love getting together - and I really actually love sector collaboration; I think it's so important, and we should do it outside of report phases, just for our own professional development and benefit and networking - but I worry that as we churn out more reports, are we actually going to see the sector reform change that we need? And anybody that gets created, peak body, statutory body, whichever body gets created, it's really only as effective as what it is legislated to do, and how long someone is in government for.

So although I welcome such authority in such a body, I would want to see that there are some objectives and some boundaries, and some limitations, or just something to the effect that it can be sustained and maintained long-term, especially because change doesn't happen overnight and it won't happen within an elected government term.

In terms of structural reform, I support the rebuild model; that would be my preferred choice. However, what I'm also really interested in is what I'm passionate about in this state, is what's being done to allow for innovative models of services and facilities. So in terms of legislation, commissioning, licensing, accreditation processes; sometimes they do limit the scope of what can be provided, and they can restrict innovative practice and new models of care and service delivery.

There needs to be investment and commissioning for both the clinical care aspect and the community aspects. And I'd also argue that whilst both are incredibly important, it's also good to note there can be hybrid models of wraparound care that can use both the clinical and the community, and can be of benefit in servicing and consumer needs.

Again, (indistinct) a little bit, say, is that there also needs to be strong consumer and carer representation with such governing statutory bodies. And I would even recommend a sort of a bit of a workforce target and quota; again, might be slightly controversial. But to ensure the inclusion of the voices are actually not merely a representation or a role that is an hour meeting, or read a document and give us what you think; but actually at the decision-making level to plan equal role on the body that actually gets developed. I think that's very important if you want it sustained, long-term.

Then lastly in terms of the private health funding and funding community-based healthcare, which is something that I've just been interested in, in this recent two years. My main point is that there needs to be key legislative changes so that private health insurers can actually remain confident of the quality of such a service in adhering to fundamental accreditation and licensing that are not currently within hospital services' frameworks.

At the moment, there is no provision for community-based care within legislation, and if we made some changes - so at the moment we've got hospital and we've got day hospital programs, and then we've got, you know, psychology sessions, but there's actually nothing community-based. So if we allowed the change to the legislation, private health insurance could actually fund models that were out of the hospital services framework, then we could

actually pave the way for innovative and cost-effective models to be initiated and also sustained, which would create less of a burden on the wider system.

And they were my points. So, any questions?

PROF KING: Thank you very much. Okay, let me start at the end first. So getting the consumer voices in any rebuild models, so getting the consumer voice at the local level, also the consumer voice at the national level, the NMHC - and as a bit of background, with any government body, you can't stop governments from changing and getting rid of - -

MS GREEN: Sure.

PROF KING: They could eliminate the PHNs tomorrow if they really wanted to, or they could completely revamp and they could sack every local hospital board in the state if they really wanted to. So there are simple government restrictions that you may like to get rid of, but we live in a democracy.

MS GREEN: It was wishful thinking. Wishful thinking.

PROF KING: We live in a democracy and we elect governments, and we give them relevant power, or they have relevant powers; we may or may not like how they use them. But sorry, I went off the track there.

So we suggest things like having consumer representation, lived experience at the board level in any new organisation that's being set up. Do you have any suggestions as to how to embed it further in organisations, to make sure that those organisations really are consumer-oriented, rather than being captured possibly by a clinical group, or possibly by other groups; so any thoughts about that?

MS GREEN: I think sometimes we don't give consumers and carers - I'll put them in as well, as equals - that we actually think that if we involve a consumer or carer that we're just going to get a nice little story and somehow we fit that nice little lived experience story into our model and hope that we've got it right.

But I think we don't give consumers and carers enough credit, in that there are consumers and carers with degrees; there are consumers and carers that have specialisations in niche areas; there are workforces that have already been set up - which I won't go into, but we could always have a private chat about that; there have been workforces already that have made a difference in certain ways.

So I think we just need to be careful that we're not employing people just to give a story. You know, consumers and carers can be screened just like any other worker or any other employee. Because I think there is a talent in being able to navigate administration, service delivery, policy development and making, and all those aspects.

But we shouldn't just restrict consumer and carer involvement because we haven't worked with them before, or because we maybe don't understand their training or their experience. We actually need to have a more thorough discussions with them to say, "Look, this is my

role, this is what we're doing. How do you see coming in and assisting us, and what's your level of expertise and experience?"

Obviously, lived experience and the carer experience is an expertise that we need to be respectful of, but also there are different niches in different areas within mental health, and we need to get really open about the discussion about what people want and how do we actually make sure that those people then align with what's happening? Because I think that's the most powerful and effective way of bringing the two together, and they need to be brought together, is my understanding and my experience.

In saying that, when there has been representation or consumer consultants, or any of those kind of views, there is the tendency to come in, have an hour meeting that they would maybe get paid for, and then talk about an issue and hope that any recommendations that go then upstream will then somehow be followed and written-in.

Why can't we actually allow consumers and carers to be paid as equal members of such a board or a peak body or organisation, to then actually say, "Okay, so this is the idea that you've got. We value your experience and your opinions. Let's assist you, or you assist us, in how we actually make that into policy and writing."

So rather than gaining the evidence from them in a silo fashion, why don't we get them around the same board table? Why do we have to employ them for an hour meeting and then they go home, and they don't know if their recommendations are actually considered or not. Why don't we make it so that yes, they've got recommendations and decisions, but actually, they follow it through with the board, with the directors, with executives, with organisational managers?

That would be my approach, because then it can't be tokenistic. If you are sitting on the same table and you are at the process from beginning to end, it can't be tokenistic; it is inclusive, it's collaborative, and everyone remains equal and works (indistinct) within. I don't know if we're actually at that point or if we've ever done that, and I could only really speak for WA.

So that would kind of be my suggestion, is can we actually work with organisations at that high level, to help them bridge the gap of understanding consumers and families how they work, and helping consumers and families understand how boards and organisations work, to make sure that administratively, and when we're creating these policies, these documents, these bodies and reports, that we can actually have a decision-making that threads all the way through. Does that make sense?

PROF KING: Yes, it does. That's good, thank you. You mentioned - sorry, I've gone right back to the beginning of your comments - the IPS programs, and you prefer them not being run through employment agencies. And I can see some of the issues that you raised.

And you prefer them being run through community health services, but I can also see issues with them being run through community health services in terms of that may not be the central mission, if I can put it that way, of that health service; that they may be orthogonal in some ways, as opposed to say, an employment agency which is aimed at getting people into work.

So should we actually be ruling out employment agencies as potentially tendering for IPS services, or is it more that the commissioning bodies need to be aware that anybody who puts in a tender will have a different background, different incentives, different issues?

MS GREEN: I think with IPS models specifically, you could have flexibility in it. See, when it works well, it works well at the local level, and very much other regional levels; it works well when it's in that community-based service within that community. So even with Perth metro, you know, your north metro is not going to be the same as your south metro, or your east metro; just as Geraldton is not going to be the same as Kimberley.

So if there is flexibility to work at the local level, that might work better. Or maybe, we need to get better at the whole IPS model in general and actually create a bit more of a structured platform to know how much it's working, if it's working, what works, and how do we replicate that? But all within a tailored community setting, and area-based service.

The reason why I said it would be great to embed it in the community mental health service is because there is already a little bit of I guess a culture shift, in terms of the community development officer positions and different positions that are trying to create links in the community and referrals and supports and services. Because yes, just from an outsider point of view, that community health service has seemed quite stretched, and so whatever links they can make with additional services is generally quite helpful.

So if you had someone like a community development officer that oversaw that, who's already got the links to other services and supports, it would make sense that that would fit within there, so not necessarily within the medical whole team, but within the clinic itself, floating around the teams and with the psychiatrist. That would be my preferred mode, just because of funding restrictions and the way sometimes not-for-profits change, regardless of whether it's an employment agency or not.

If, however, the phasing-out of the employment agencies with the IPS model would cause considerable concern, evaluation would definitely be my point forward in making sure that the models that we do have are working well, and that it's a little bit more broader scope, because I feel like it's a bit hit and miss at the moment and we don't really know why it's hit and miss, and what's working, what's not. So that would be my suggestion.

PROF KING: Okay. An?

MS TRAN: So a question around the advocacy service. Which type of advocacy service are you talking about? Is it - - -

MS GREEN: Sure. So WA had a mental health advocacy service.

MS TRAN: That's right, yes.

MS GREEN: So again, it was pretty well Perth metro, although I'm sure it's regional so it would be more a phone call from this end. But it actually doesn't matter which service it is; it could be any advocacy service: it could be a locally based advocacy service, or a national

one or a state one. The main thing is that we actually need to communicate to people in a way that while they're overwhelmed and frustrated and unwell and stressed, that we somehow communicate to them that it exists, no matter what it is that exists, just that it exists.

Because too often, I find a lot of workers then debrief after the fact and said, "Well, didn't anyone tell you that you could've accessed this service?" And I always get from my hearings around the ground, a resounding no. And that worries me a little bit, because we have an advocacy service, why aren't we utilising it, and why aren't we telling people in a way that they can understand and appreciate that it exists?

And I'd like to see that statewide, nationwide; regardless if there's a different body per region and per state, it doesn't matter, but the way we communicate it needs to actually be more explicit, and also more accessible for people to understand it and then link in with it.

MS TRAN: Yes. And you mentioned that you wanted that access to be, for example, you could have brochures in EDs and whatnot.

MS GREEN: Yes.

MS TRAN: Is that because the typical consumer would want - non-legal advocacy services would be usually in the hospital setting? Are there other, you know, settings that non-legal advocacy services could be better accessed, I guess?

MS GREEN: I think the difference is that for not-for-profit organisations community mental health services, there are routes to sort of raise your voice; I'm not necessarily saying it's always easy. But through things like feedback and complaints, and you know, people can speak to a manager or a team leader, their communication channels can be a lot easier for someone to actually take notice and respond quite quickly.

Unfortunately, with your in-patient facilities, because it is run like a hospital or emergency department, it is mainly focused on the physical care, the here and now, and they're not necessarily used to linking in with community agencies and services, and that pathway of communication, where we're looking after their emotional and social needs, not just the imminent physical ones.

So absolutely, generally what happens within advocacy services that I've experienced is that it's always within the main facilities, because at community level not-for-profit, there can be complaints, you know, people can ask to change workers and different things like that; we don't have anything like that in ED or in-patient because it is just its own system, its own unit. So that's where I think where we need it the most.

MS TRAN: Yes, thank you.

PROF KING: Thank you very much.

MS GREEN: Thank you.

PROF KING: And next we have Cathy. Hi, Ms Fox. So if you'd be able to just state your name, if you're representing an organisation, which organisation, and then if you'd like to make any opening comments.

MS FOX: Sure. Welcome, thank you for having me. I'm Cathy Fox. In between jobs at the moment. I also was part of the establishment of the Consumer and Carer Advisory Group for Midwest Mental Health; I also sit on the WA Country Health Mental Health executive board; I also do accreditations in hospitals as a consumer rep.

And I'm representing myself as a consumer here today, but I also speak from a vast knowledge of what the sector offers, what the gaps are from a consumer perspective. I could also go into a carer perspective, but I won't because I'll keep it limited to that. So that's who I am. I'm a mother of six children, one deceased, and 10 grandchildren, and probably growing, I hope. So there is my experience. And can I start with a short story?

PROF KING: Please.

MS FOX: So in my work life previously - because I am 60 now so I know the government wants me to work till 70, but currently I'm not - in my experience there were two young children, five and seven years of age, who witnessed their father hanging himself in their lounge room. The school, the local school, was fantastic and they called the school psychologist, who refused to come because it was beyond that psychologist's expertise, and they didn't feel confident to debrief the children.

So the school then rang Mental Health in Geraldton, and Geraldton said the CWMHS worker is on holidays, so they wouldn't come either. These children were deeply traumatised, as you can imagine. An NGO adult worker went and saw them with an Aboriginal liaison officer, who was also an adult worker; went to see these kids. Deeply traumatised. I actually went and saw these kids; very distressing to go and see the struggle this family was having.

Three months later, those children had not seen a clinician. I actually wrote to the Chief Psychiatrist with a complaint, Mental Health with a complaint, which is why I'm not on the exec board. That's what happens if you raise a complaint. Because the services in remote areas simply are not doing their job, and these kids were greatly missing out, and it just breaks my heart to see young children traumatised and suffering like that.

So I bring that story to you because I think it's a very important story, and it's what we're on about isn't it? It's about where is it falling short? Well, out in remote, that's where it's falling short.

I have a few other things to say.

PROF KING: Yes, please.

MS FOX: So although there is a need for crisis - can I just read it, is that all right?

PROF KING: Yes, please, that's fine.

MS FOX: So although there is a need for supporting crisis mental health work, if more preventative measures were invested in, then the need to support crisis might reduce; no-one knows for sure, as we have not yet invested widely in it.

Standard 5.1 of the Mental Health Standards says that the service develop strategies appropriate to the needs of its community, and promote mental health and address early intervention, and prevention of mental health problems. So there needs to be a responsive and sustainable partnering with consumers and carers and NGOs, which provides holistic support and care to those in need. And if we got in early, then there may never be a need.

One of the gaps here is that there is no private psychiatrists for the midwest, and mental health services here are already snowed-in with the severe and challenging clients that they have. The gap for those with chronic mental health psychiatric needs, with ongoing consultant needs, is just enormous.

So I see a psychiatrist, I see him once a month; I have to travel to Perth to see him. I have done a Skype visit with him, but it just is not the same. In order for me to go and see my psychiatrist, I have to either fly or drive, which is quite costly, and then I need to stay the night because I'm too tired to drive back the next day. It's extremely expensive to do that.

And so I'm not alone, and fortunately, I am financially secure so I can afford to do that. Now, there are plenty of people here in the midwest who have chronic mental health problems that need clinical support, who fall outside the gap of mental health services, and are unable to access a private psychiatrist because they simply don't have that kind of money.

Another problem alongside that is the lack of bulk billing GPs. So people avoid seeing their GP because they simply can't afford to go; it's about \$75 to go and see your GP, of which you get about, I think, 40 back. but if you're on a pension or Newstart, that's just not doable. Then there is the problem of paying for the scripts. A lot of mental health scripts are quite expensive, so if you're on a pension you just can't afford it.

In 9.4 of the Mental Health Standards, it establishes links with consumers, nominated primary healthcare providers, and that can't happen if they don't have one. So we really need some bulk billing GPs. People that need a second opinion have to travel to Perth, and very expensive. There is also no face-to-face counselling available here in the midwest for carers, so there is the phone counselling service that HelpingMinds provides, but there's nothing better than a face-to-face person that you can actually debrief on, that understands your problems.

There is disproportionate financial impact on those requiring mental healthcare, and that's because a lot of them are unable to work, but do not fit the bill for Midwest Mental Health services; in remote areas, it's even worse, with no way to access counselling of any sort without a phone, which many people in remote areas do not have, or don't have sufficient phone credit to allow for lengthy sessions with private practitioners.

And this is a major problem even in Geraldton, When I worked for Mission Australia, there were lots of my clients that didn't have phones. And the other thing with some people with

mental health problems is, they are very good at losing phones and things like that. So it's often a huge problem.

There is urgent need for mental health beds in Geraldton. I know we've got them coming but it's an urgent need now, as the risk of sending people via plane to Perth for treatment is very risky. Consumers must be significantly medicated to fly. So at 1.9 of the Mental Health Standards is the right of the consumer to be treated in the least restrictive environment, to the extent that it does not impose serious risk to the consumer or others. And I put it to you that sedating somebody to unconsciousness is a serious risk to their health and wellbeing.

And 7.7 of the Mental Health Standards - and I refer to them because I know them - that the mental health service considers the needs of carers in relation to the Aboriginal or Torres Strait Islander persons, and the culturally and linguistically diverse persons' religious, spiritual agenda, sexual orientation and socioeconomics. So these are all things that they need to consider.

A sideline to this is that if someone wants to access a mental health advocacy service, which my colleague talked about earlier, then this is only available by phone or Skype. People can't get a face-to-face meeting here in the midwest, with a mental health advocate, which is appalling, because we're not so tiny that we couldn't have one.

I know there are three cases where consumers were not given their legal rights of their paperwork prior to entering into the tribunal mentions; so as they were walking in, "Here's the paperwork." How can you represent yourself and defend yourself if you don't know what the charges are before you head into the court? So this is a huge problem that needs to be really be addressed.

There is also a need for crisis teams to work alongside and within the emergency support services. And I know of somebody whose wife rang and said their partner was suicidal, and he was walking down the street in a country town. And the police saw him, they put their sirens on, pulled up, handcuffed him, through him in the back of the car and drove him up to the hospital - so he's hugely embarrassed - only to be released 15 minutes later by the hospital, and this is really a lack of emergency services understanding how to work with somebody in crisis.

Education for all emergency services is what I'm recommending. Recovery-based education, definitely peer led, so consumer and carers delivering that training, because hearing that from those that are using the services will have a better impact and outcome.

Medicare rebates for holistic service providers such as art therapists, because a lot of people can't relate to going and talking to a counsellor, but get an enormous amount of benefit from somebody like an art therapist. Currently there's no Medicare rebate for that, so it would be good to consider that.

Dental costs are incredibly prohibitive and the mid west dental service is already overrun with people, and you can only see them if you have a health care card, and this leaves many people without the ability to afford appropriate dental care, and my own story is every time I

got a rotten tooth, which thanks to the medication I was on was quite often, my mental health would go through the roof and I would end up in hospital until that tooth was fixed.

So there's a definite link between bad teeth and poor mental health. So somehow the government needs to fund dental services so that people with mental health problems can get those - their teeth fixed, because that might be all they need to be well.

Dentistry education for children I think is important, because we really want to start young before they're adults, before their youth, before mental health begins, and teaching children how to clean their teeth and the importance of how it impacts the rest of your life is something that I never got as a child and would be I think hugely beneficial to children. I also think we should provide free toothbrushes to every child so that nobody misses out, because a lot of kids don't have toothbrushes because their parents don't have money to buy them or they have never learnt to clean their own teeth so they don't see why it's important.

There's a lot of children in the mid west who have food poverty, and I know this has already been spoken about by people, but food poverty is a major issue here throughout the mid west. So one way that I think this could be addressed is if all schools provided a hot lunch for kids no matter what their socioeconomic status is. So it's free, lunch is just part of the service. It might seem expensive, but providing good nutrition sustains mental health.

Getting people moving and exercising is very important. So I'm giving you the holistic viewpoint because that's what got me well was eating well, exercising well. So I wonder whether we can have some sort of program that provides young people in particular with some sort of funding so that they get the opportunity to engage in playing sports or art activities or music activities so that their minds are filled with healthy things rather than anxieties. So meaningful activity is shown to reduce the risk of addiction problems as well and has benefits of building healthy bodies.

We need a peer led and community supported drop in club of some sort for those who are lonely, somewhere people can stop and chat with friendly people, and this might reduce loneliness, depression and suicide. Men's Sheds are doing a great job across the country, but not everybody can join a Men's Shed.

The other - my last point is that it would be really great if we had free quit patches for people with mental health problems because 80 per cent of people that smoke have mental health problems. So it would be really good if the Quit campaign addressed that part of the campaign of the people with mental health problems. Providing patches might be a good beginning. I think that's it.

PROF KING: Thank you very much. I'd like to ask you some questions about a few of the areas. So with regards to both advocacy and psychiatry you mentioned phone, Skype and so on, which has its own limitations in terms of access, but I wonder if you - yes, face to face almost always is better. Not for every consumer, some consumers prefer the anonymity of online or prefer the anonymity of phone services, but of course we have a limited workforce both in advocacy and the clinical workforce and everywhere else, and with the large distances. Have you thought about other alternatives? So for example I know on Cape York there is visiting psychiatrist services, and I know there are different views about their

effectiveness, so I won't go into the details, but have you thought about whether - are there other programs that you've thought of or you're aware of that may sort of bridge that gap, so it's not face to face better than community, but it may also be rotating as something like that. Any thoughts?

MS FOX: My thoughts on rotating psychiatrists is that you wouldn't get a good service. You have to build a relationship, you have to know the person, they have to know you, although that would be better than nothing. Currently in the mid west we have visiting specialists of all sorts of different specialising areas that meet at St John of God, but psychiatry won't come, and it really is a huge shortfall.

PROF KING: By the way you?

MS FOX: So I need to see a psychiatrist at the moment and I have to go to Perth for it.

PROF KING: And going to Perth is - - -

MS FOX: And it means that - so I ran out of medication on Friday, but I'm not seeing him until Monday. So that meant I had to go to the GP to get that which cost me extra money and all I needed was the scripts. But I couldn't ring him in Perth and get them because it's all very complicated.

PROF KING: I will come to that in a second. By the way your comments on the problems with visiting psychiatrists were exactly the ones that have come up in Cape York. Maybe they should have asked you before they did Cape York because that was really good. Just on the pharmaceuticals and the bulk billing GPs. We haven't addressed it a great deal in this inquiry because there have been other inquiries including one I was involved with, although not a Productivity Commission inquiry, looking at pharmacy and scripts. How do you find the subsidy for the medicines, the safety net - I suspect a barrier at the moment with your psychiatrist in Perth is that formally you have to have a bit of paper. A script is a bit of paper in this country, it's not an electronic record, which hopefully is going to be changing fairly soon, but can you just expand your experience for example - I am not sure if you've reached the safety net or whether you're eligible for the subsidised medicines versus the standard co payment, but just your experience with the medicine system.

MS FOX: Well, years ago I was put on Lamotrigine before it was on the - - -

PROF KING: PBS.

MS FOX: - - - PBS, yes, and it was about - I think it was over \$100 a month unless you had a specific type of epilepsy, which I didn't have, but at that stage I was in hospital an awful lot and I was living in Canberra at the time, and the Prince of Wales, which was the mood disorder unit, recommended it. So the hospital in Canberra met and decided they would pay for the medication for me. So I picked - they kept me in that medication for about two years where I would just go in and collect it once a month, and at the time we had no money, so - you know, I wasn't working and we had a lot of kids. So that was a real blessing to our family. But that's what medications are like, a lot of the psychotropic drugs if you don't fall

into the right category you don't - you have to pay the extra money to have it. So if I was on a pension it's just completely prohibitive.

Currently I'm on an antidepressant which is \$75 a script, because it doesn't come under the PBS either. I take - I can't take the prescribed antipsychotic for me because it knocks me out for two or three days straight. So I'm on another one which is only available for people with schizophrenia, so again that costs me about \$80 a month. So if I was on the exact things for bipolar it would be like half that. So these are the things that people have to deal with, they have to make a decision as to whether they're going to forfeit something else to pay for their medications or take the ones that the government's already said works, even though they weren't working for me, and when I got on the right medications my health improved and I no longer needed hospital. So the government suddenly saved a whopping amount of money because I used to be in hospital a lot.

PROF KING: That's really interesting because it's something I will confess I hadn't thought of and I should have, but of course you can have medicines that are listed on the PBS, but unless you've got the actual diagnosis that matches up with the medicine you don't get the PBS subsidies.

MS FOX: That's right.

PROF KING: Which I can sort of understand physical health, but in mental health where - we've talked to people who have had five years five different diagnoses before they eventually get correctly diagnosed, and you sort of think, well does that mean you just fall through the gaps for five years because there isn't that match there. So thank you, that's something we hadn't thought of, and I think it's important. I've got a number here, but let me do one more before passing over to An. You mentioned beds, mental health beds in Geraldton Hospital. So we see a shortfall - so in our report you'll notice we see a shortfall in the acute hospital beds. We also see an even bigger shortfall in the subacute and in the community beds. So when you were saying that there's a shortfall in beds in Geraldton Hospital is it just the hospital, do you think it's broader than that, are you aware of what are the number of beds available outside the actual hospital setting?

MS FOX: Well, in Geraldton there's two allocated beds that psychiatry can use for a population of - I think there's about 60,000 in the mid west. I'm not sure, it could be 80. Someone will tell me. That's not very many beds, and the average - I don't know what the average stay is, but I had the distress of having somebody admitted who was extremely suicidal, an Aboriginal over the age of 50, who was only kept for two days, which is atrocious, and five days later he was dead. So I feel that we need the right - a greater number of beds and we need a greater number of bed stay days, so that somebody that is really suicidal can actually get some proper therapy and currently they can't. There's no step up/step down here yet. It is coming, but how many people are going to die whilst we're waiting for these essential services. Step up/step down is a brilliant thing for the community, but it's obviously quite a way away, and people are struggling now. So, you know, we need it.

PROF KING: Thank you. An?

MS TRAN: Just a question on - thank you for sharing first of all - so you spoke about a holistic approach towards recovery and I was interested in hearing about how - what helped you most in your journey towards recovery.

MS FOX: Thank you for asking that one. Can I just say that I'd been told by doctors I would never get better and my husband had been told pretend she's dead, and that way when she's in a good headspace you can celebrate and enjoy being together, and when she's not, well you won't be surprised. Great support there. So I went through a period of great deep mourning of who I had lost, and my identity was completely gone, I felt shame and all things just made my mental health worse, and one day somebody else got better in front of me and I thought she was a lot more crazy than me. So I thought if she could do that I could. So what was she doing. What she was doing was when she was having a bad day she'd just go to bed for the day and she'd be right for that. That didn't work for me because I can't go to bed for the day. I just can't do it.

So I needed to find what worked for me, and essentially what worked for me was exercise, and not just a little walk down the street, but profusely sweating exercise, eating a healthier diet, so I changed my diet, which by the way people can't afford a healthy diet because it's expensive, and I made a list of all the things I liked to do before I got sick and I determined that on the days that I was feeling really rotten I would force myself to do those things because that's what I used to enjoy doing, and I made a list of goals.

There's a scripture in the Bible that says people without a vision perish, and they do. You've got to have some goals, something you're working towards. So I wrote a never ending list of goals, so I add to it whenever I need to. It's astounding how you put a goal up there and it happens. We had no money. One of my goals was a hot air balloon ride. I went to school for my daughter's performance and one of her friend's father's was there and the principal was being really sweet to him, and I was standing there and he said, 'Yeah, I've got a hot air balloon', and the principal said, 'I wouldn't mind having a ride', and I went, 'No, take me.' Anyway he did. So, you know, that's how good writing a goal down is, that even though it's outside your ability to do it somehow things happen and you get those goals met.

Holistically, so I invested in reading books on what I could do to help myself. I read widely on other people with my diagnosis what they've done to get well, and I took the parts that worked for me. Everybody's different, so that won't work for everybody, but there is something that will work for that person. I think the number 1 is you've got to give yourself credit for where you're at that time and love yourself, and then start to look for what works. But having things like holistic care, so being able to access therapy, music therapy, that kind of thing, those things all help.

PROF KING: Thank you very much, and thank you as An said sharing your story with us, that's been fantastic.

MS FOX: It's a pleasure. Thank you for having me.

PROF KING: Next we have Leslie-Ann Conway. Thanks, Ms Conway, and if you would be able to state for the transcript your name, your organisation and if you'd like to make any opening comments.

MS CONWAY: My name is Leslie-Ann Conway. I represent the Geraldton Regional Aboriginal Medical Service, and I know there may have been acknowledgement which Elaine and I may have missed earlier, but I'd like to acknowledge other Aboriginal people in the room and certainly the (indistinct) and Yamaji people. I'm a (indistinct) Ballardong Noongar woman, I'm from the south west. I'm working off country. In a previous life I lived and worked in Kalgoorlie with an Aboriginal child and maternal health service known as (indistinct), which means many mothers and children, and I'd also like to pay respects at this particular point in time certainly to the Clark-Jones family who had recently lost a family member who was tragically shot by police, but it was well known that she had a number of mental health issues, and we know from supporting the family that in that whole situation the family had rung the police as first responders because they were unsure about how to help and they wanted aid to help their sister sort of in her sort of traumatised state about what they could do for her.

I suppose the basic premise my colleague and I have been talking about, the premise of this conversation is certainly around what we see as systemic failure for Aboriginal people in what it is around the fields of employment, health, justice and housing, and GRAMS deals daily with vulnerable people in trauma who are dealing with these types of systematic failures.

If I could just give a basic, a real story about Aboriginal people's world views. My brother most recently had open heart surgery and he was at a specialist centre in (indistinct) and there was an Aboriginal family, countrymen from the western desert - and this is just to give some clarity to a world view, because I know a lot of agencies here receive money for specific Indigenous services for our people here in the mid west Gascoyne region.

So getting back to the story what had happened was my brother was seeing the cardiologist and he'd gone up and down the lift a couple of times and he came down and he talked to the countrymen in the corner and he said, 'Would you like me to accompany you up to the lift? I've just finished my appointment do you want to go up?' And they said, 'We're not going in that machine', because they would see people going up and when the lift came down the person was different. So there was no way just in terms of access that those Aboriginal people were going to get into that machine to access the service that they needed to. So Simon said he took them and explained to them. So he spoke to the cardiologist and that was - that was the sort of situation that I think where you can - you can try and elicit from that story that whilst you might have the best intentions and have so much empathy you're still not Aboriginal, you don't share the same world view.

So I think it's quite significant when you look at situations where you have to take heed to the number of reports that have been done around Indigenous health, around Indigenous mental health, that services have to come to Aboriginal organisations to make a sense of what's going on in our world, and predominantly the Aboriginal community controlled health services that had been in good stead over the last 40-odd years prior to 1967 - sorry, post 1967 - the Aboriginal medical services have been around for a long, long time to be able to provide those appropriate services.

So just basically what I wanted to do was just to make a presentation, and you've probably heard this all before about our particular model, and if I could just read from this about what GRAMS does. So GRAMS is a community controlled organisation offering an affordable and culturally appropriate health services throughout the mid west, Gascoyne and Murchison community. So it's a huge - it's a huge geographical area which we struggle with, but then we take that on board as well, because of a nomadic and transient nature anyway is Aboriginal people, so travel isn't really off centre, and particularly I suppose I would say that to a lot of people who live rural and remote anyway.

So through resident and mobile services we work collaboratively with service providers to offer a range of comprehensive primary health care and mental health care programs. GRAMS believes in promoting healthy lifestyle, social and emotional wellbeing and early interventions. Our programs through GRAMS are embedded both in the tangible and intangible cultural frameworks around our own identity and spirit. These cultural frameworks are cognisant of the cradle to the grave approach, which encompasses the breadth and width of complexities within our Aboriginal populations throughout the mid west.

One of the programs I will speak of quite in depth is certainly our Maga Barndi Social and Emotional Wellbeing Support unit. Now, we try to deliver this program, or we do deliver this program and the AMSs work on a holistic model and we find that's best practice. We have a local - not local, a regional or a state peak body, which is known as the Aboriginal Health Council of WA, and of course there's a national peak body which is NACCHO. So they represent us on a more national and strategic level.

So certainly the Maga Barndi unit itself it consists of a social support coordinator, a social worker, psychologist, social health trainee worker and two Aboriginal mental health trainees. The team provides holistic and culturally appropriate social support services to support families and individuals in complex crisis. Counselling is available for adults and children for depression, anxiety, trauma, anger management and post-traumatic stress disorder.

Most recently GRAMS has initiated a number of grief and loss space support programs. We find that a lot of grief and loss and trauma is all that enter generation and it's across generations and we deal with them daily, and this is also to address the recent spate of suicides throughout the mid west as well and the complexities that affect families post suicide. We have an out of home care support group to families who have had their children taken into care, and we also work with families who have had their children removed. So there's two distinct groups there, who suffer trauma and mental illness and anxieties around this whole process.

We have a twilight blue men's support group to tackle men's depression. We have a youth alliance and leadership support group to assist young people and older youth to tackle their aspirations and the complexities associated with their own aspirations. More importantly GRAMS also in the grief and loss space we work and have an unfunded program for the last 35 years around returning our people to country. So what we do is we - if someone dies for whatever reason, whether or not it is through suicide, whether or not it's just through a normal morbidity where they may be (indistinct) in Perth, what GRAMS does is facilitate the return of people to country. I think the longest trip we did is we went from Geraldton to Port

Hedland, Port Hedland to Meekatharra for the burial and we came back to Geraldton, but that was to assist the family in terms of their own economic disparity.

So we take that cost off them and GRAMS wears that, but that's unfunded, we do that out of our own discretionary funding. But over 40 years I believe we brought 1,010 people back, 1,010 people back in the 40 years which equates to close to 25 people a year, which is one a fortnight. So therein lies its own statistics about what we need to do and what we continue to need to do.

So I do certainly agree with a lot of the comments that have been made by everyone that's presented here to the inquiry. We have a number of other programs and I'll go into them. We have bringing them home, which assists the stolen generation, families of the stolen generation, which are a particularly dying sort of breed of sorts, but what we find is obviously the enter generational sort of effect of that.

We have the family health unit which deals with our infants and youth from zero to 14; the chronic disease unit which is all other populations. We have a regional tobacco program, and I agree with what Cathy says about, you know, patches for people that are really stressed and what not. Yes, we have a program through - we have that sort of ability through our (indistinct) program. We have a more than medicine program where that's health and exercise and diet and everything else that we operate with. We have a relationship with (indistinct). We have student health nurses and doctors coming through GRAMS and our Centre of Excellence, and we have an integrated team care program.

So whilst we have a lot of resources we are still seeing ourselves as under-resourced. Most recently we've been funded through the Western Australian Primary Health Alliance and I believe you have a copy of this of our most recent suicide prevention project, and in that particular project what we found quite damning for ourselves in terms of the services that are meant to be provided to Aboriginal people, what people were saying and which is reflected through Alastair Hope's coroner's report from the Kimberleys in 2008, the Royal Commission into deaths in custody in 1991, and Ros Fogliani's most recent report as well of the death of the children in the Kimberley, they were saying the same things, that Aboriginal people are not accessing the services.

So how much does it take for Government to realise that there needs to be more recognition? I mean, most certainly with the devolvement and the abolition of ATSIC in 2006 and I've worked with them, and Indigenous specific funding going mainstream, that certainly opened up.

MS TRAN: Yes.

MS CONWAY: Let's say a lot of the faith-based organisations with the best intentions and you believe that there is sometimes that whole preservation of thinking around, well, from an Aboriginal perspective, about people still think they know what is best for us. So that puts us in another position about us being credible enough to stand up and I believe – and I'll leave a copy of these with you – is when Debbie Woods and Sandy Davies, most recently, had made a statement to say that they were calling on both the State and Commonwealth to support peak health services for Aboriginal people and providing two full time psychologists and at

least six full time mental health practitioners, and if combined, the State and the Commonwealth could provide long overdue rudimentary mental health needs for the forgotten and neglected Yamatji people. Four full time psychologists and at least four full time Aboriginal mental health practitioners.

So it was reported most recently, and I don't want to regurgitate lots of stuff that has been said so far, but we'll state here and it has been stated, that in 2019 stand-alone, (indistinct) Yamatji people are tragically the nation's highest suicide rate with more times the suicide rate of the (indistinct) First Nations people.

So when you take all of that on board, holistically, what's happening out there in the community and with Amy in the room, I must, too, be thankful that stage 2 of our suicide prevention report has been funded. And I briefly discussed this with Amy because I said I would make reference to it. So initially when GRAMS made funding for an elevated amount of money which was close to \$700,000, but that negotiation had been reduced to a lot less than that. So what we thought from a very critical level, we thought are we being thumb-nailed and screwed over again? Because we're being given a reduced amount of funding to do a more of an area. So we're doing three locations, so in terms of scales of economy, certainly you would wonder about how relevant that would be about the delivery of what it is that we do for our people.

But certainly in my conversations with Alistair earlier this week around the enquiry and the hearing, it was that we needed to have the voice of our people heard and it was as I mentioned, where we talked about having no credit on your phone to have access to just call someone and to know that someone is there and you are not alone. Little things like that mean a lot to people. So GRAMS in itself, what we do is that we provide a lot of self-help and management. We have the long intensive care and certainly the moderate intensive care – intensity care, which we give to our clients. And I will say that in our more remote communities, in particular, our outreach clinic in Mount Magnet and I'm not sure about Carnarvon, but I know in Mount Magnet it's 48 per cent are non-Indigenous clients. So, again, you wonder to yourself if they're, it – you know, how well do we service the whole of the community. And phase 2, I might add, we'll be going into community action plans, because what we believe is that services can be funded forever and a day and services can visit forever and a day, but how do you make it sustainable within community for them to be in charge of their own health destiny and their own well-being.

So hopefully, that's what phase 2 will focus in on. In the locations I mentioned, Mount Magnet, Geraldton and Carnarvon. But I don't think we really wanted to mention anything else. I know that we did talk about wanting to say that also the premise of we think that – and my colleague works in the Maga Barndi unit where we're dealing daily with people who are affected by abject poverty, food security and insecurity and we think to ourselves that possibly more of those models could be integrated because we're working with Thirrili, who won the National Indigenous Crisis Response Unit. We're also working with Jerry Georgiadis around the National Trauma Response and Recovery Project which enables us to say, well, if you need \$300 for food and \$200 for petrol, then on the spot we're able to provide that service through having those links and networks. Certainly GRAMS bucket is getting drier and drier but that's why we rely on other strong partnerships.

We certainly think that these systems of failure are relative to basic human rights of everyone which is around food, water and shelter and more often than not, when people are coming to us, it is around the issues of those three basic rights of food, water and shelter. The first thing they ask when they come in to see anyone is can I have a cup of tea or is there a bottle of water because it's – whatever, they need whatever. So we wonder about those sorts of premise, those sorts of systems and how they continue to disadvantage our people. And certainly in terms of what we believe is – with – my colleague has worked quite closely with Harry Blagg from Western Australia. And he's done a lot of work around family and domestic violence. And we believe that in terms of his opinions around the three deterrents of vulnerable people and more particularly Aboriginal people about accessing and reporting crisis is that there is fear of removal of the children. There is only services off-country, which means you're being removed from country. And that certainly there's fear of retribution or incarceration. So those are probably the three main sort of reasons that when we unpack our daily work load of what it is that we do with our clients, that one or two or three of those will be quite prominent in people's reasons why they don't go to other services as well.

So yes, GRAMS will, in the offing be presenting and doing a more in-depth response to the submission – to the inquiry and have a formal submission prior to January 2020. But in saying that, I would also like to say that I agree totally with all the recommendations that were done with the Indigenous evaluation strategy where the Institute for Urban Indigenous Health made a submission about what it is that we need to do in terms of evaluation funding and all sorts of different things about how to make the world a bit of a better place for not only Aboriginal people but all our vulnerable people. And other citizens as well. So yes.

PROF KING: Thank you.

MS CONWAY: Thank you.

PROF KING: So, if I can ask a few questions. So in our draft report, we recommended draft recommendation that for suicide services provided to Aboriginal and Torres Strait Islander peoples, that the preferred providers should be Indigenous controlled organisations.

MS CONWAY: Yes.

PROF KING: So I'd be very keen to get your feedback on that recommendation. In particular, and we had a debate and we recognise we're not Indigenous people and so we want to make sure that we're talking to the people who will be effected by our recommendations, that we've got it right. So we said Indigenous controlled organisations rather than the (indistinct) for example, and I'd like feedback on is that right? Are we moving in the right direction there? We'd limited it to the suicide services. We had a significant debate internally on whether we should be going further. But we thought we should go back and get more advice. So I would ask your advice on should we be thinking much more broadly. We did also want to get advice on the mix of services, so the fact that there are Indigenous controlled organisations providing services to Indigenous Australians does not mean that there are not also the mainstream services that can be accessed by the Indigenous Australians.

And I'd also – so feedback on that – sorry, so let me stop it. So I've given you three things initially, yes.

MS CONWAY: So, well, I'm currently involved on behalf of GRAMS in an Aboriginal community controlled organised (indistinct) strategy which has been developed by the Department of Communities. So we won't go there with the Department of Communities and what's happening at the moment.

PROF KING: All right. Fair enough.

MS CONWAY: But yes, most certainly, we think to ourselves well, this is my own opinion because I've been a public servant as well as not-for-profit for the last 18 years. But certainly, you think to yourself the whole thought around co-design and co-production, I think there's a relevant space for that to happen. It can't just be a word and a tool. There has to be real integration of thought and what that model would actually look like. I know that I'm also involved and have been involved with the Department of Finance on a number of strategies around procurement and tendering. And I think sometimes even those methods of procurement and tendering, sometimes put Aboriginal organisations on the back foot when you're looking at an ACCO not an ACCHS.

So if you're looking at just a community controlled organisation but not necessarily a health service, so then you wonder and this is what the whole ACCO strategy's about at the moment. How do we ensure capability as well as capacity and we're saying, well, my argument is well, the ACCHS are already in that space. So how could you combine the ACCOs and their lack of capability or capacity with organisations say like headspace or with HelpingMinds or whatever the case might be. How could you integrate a really good service model and even in terms of the procurement and tendering, those – it must be even more so to find a detail, do you know what I mean?

PROF KING: Yes.

MS CONWAY: So it's not that, oh, GRAMS is going to provide the transport and the sausages and you know, headspace will provide the clinical side. There has to be a real conversation, an authentic conversation if I can say, around those sorts of pliable sorts of terms and elements in a contract and how you would work through that. But that's just one basic element of the whole conversations.

PROF KING: Yes.

MS CONWAY: So the other – I hope that may have answered some of your question.

PROF KING: Yes.

MS CONWAY: The second part that you wanted me to talk about was - - -

PROF KING: So – well, actually, just before we go onto that. So from that can I say so in a sense to get that conversation, do we need the Aboriginal Community Controlled Organisation in the sense it's got to be the centre of the service delivery model. So rather

than saying, you know, we want these services for an Indigenous community and yes, well, there can be a model put together that has some Indigenous representation or some – say, involvement of an ACCO in it, do we need to go further - this is from your answer – and say the Indigenous organisation, the ACCO or Aboriginal Community Controlled Organisation has to be the central element in the conversation that has to be around that element. Am I getting it right or not?

MS CONWAY: Yes, I think so. But I think for so long, Aboriginal people have been on the peripheral and the inclusivity or the word inclusivity is a word. So people who actually want to include you for a genuine purpose will include you.

PROF KING: Yes.

MS CONWAY: And I think that's why we stand back a lot because there's not a lot of trust because of the systems of the systematic screwing of us for so long. So you sit on the outer until you sit, well, what's going to be pleasurable to us or what's going to help us achieve our aspirations.

PROF KING: Yes.

MS CONWAY: And I will say with Amy in the room, certainly with West Australian Primary Health Alliance, in stage 1, we had a lot of flexibility around our reporting in terms of the timeliness of our reporting. There was a huge lot of flexibility which allow for the way that we delivered the project and the way that we worked as two old bush chooks, what we did out there. And how we best work with community. And I will say that certainly phase 2 and there will be an evaluation, because the mid-west is a trial site. And I know that there's going to be an evaluation by the University of Melbourne in March and whilst we're taking that into account with the suicide prevention project what's happened is with stage 2 funding which is sort of unheard of but not really, and we understand that representatives of WAPHA have sort of gone into bat with the Commonwealth.

Now, they're allowing us to go right through to December 2020. So not only the contract period when I believe that will be completed, the suicide prevention – that trial will be ended in 2020, but they're going to allow us to go through to December 2020. So something like that, just pure and simple understanding of how we needed that time.

PROF KING: Yes.

MS CONWAY: That whole time to do what we needed to do with community and other service providers, and users and certainly those that are, yeah, it just makes sense and we're glad that is has made sense and we're glad that it's going through to December 2020. So we've literally got 14 months for the program. We're initially, but again, getting back to the scales of economy, three locations, less of money than we ask for, so maybe that's sort of the buy-off. So yeah.

PROF KING: How broadly should we go? So the second part, I think I mentioned, was how broadly should we go? So should it be – so we – rather than just suicide services, should

it be that Indigenous controlled organisations should be at the centre of all mental health services provided – sorry – it’s a wrong way of putting it.

Indigenous controlled organisations should be central to all mental health services provided or available to Indigenous Australians. Not necessarily provided to, because there are still mainstream options and the individual can choose.

MS CONWAY: Of course, of course

PROF KING: So should we go further? And if so, I mean, is that practical? Are we starting to get into clinical areas for example where there may not be an Indigenous workforce? I’m not sure about the practicalities of how far we take this.

MS CONWAY: I think again, getting back to that co-design and co-production. I think that you could find, I think, my own opinion is that there could be a workable model if you could get people that were willing, as I said, to have those authentic conversations, a bit like the Stephanie Alexander shared table stuff, ‘what do you bring to this table?’

PROF KING: Yes.

MS CONWAY: So you know, I think those sorts of things need to be had and resources and money can happen once that happens.

PROF KING: Yes.

MS CONWAY: But who ensures that that happens? Is it WAPHA? Is it the Commonwealth? Is it Western Australia? Because we’re predominantly funded through State Health and Commonwealth Health.

PROF KING: Yes.

MS CONWAY: So who does that? Is it the procurement and tendering service? We’ve talked with the department of finance about having pre-engagement conversations. Even prior to you putting in a tendering, do you need to have that – you can have a tick box. We call it the black tick box. Yes, we’ve got a partnership with GRAMS. Oh, yes, I spoke to (indistinct) twice on the phone last week. So therein lies someone will say we’ve got a partnership with GRAMS. Well, no, you actually haven’t.

PROF KING: No, you don’t. Yes.

MS CONWAY: But for people who are looking already at a tender, then they’ll say, well, you know, they’ve got a partnership or there is a perceived partnership which they perceive and imply in their tender, but it is on the ground not a relationship. So therein lies my issue about do we need to look at those processes or pre-engagement or pre-engagement to tenders.

PROF KING: Yes.

MS CONWAY: And who drives that? Department of Finance? Whoever the department might be, who's seeking the service from within community. So for me there's a lot of validity around that. And it brings a bit of – yeah, and it would allow for the space to be open enough for people to be quite honest with each other without any trump cards hopefully.

PROF KING: Yes, no, that's really – that's a really good point that the issue is, yes, who's responsible for making sure - - -

MS CONWAY: For that.

PROF KING: Yes.

MS CONWAY: And it's the accountability stuff which is where Ben Wyatt had alluded at some stage the Western Australian Aboriginal Advisory Council maybe devolved in terms of thoughts around an accountability of permission, were they talking about? To making services responsible for their delivery and how accountable and how productive and possibly even the social impact measures. And I think that's a really important conversation to have around changed behaviours as well, about how important that would be when you're looking at whether or not a service was providing accountable services for Indigenous Australians. So – and other vulnerable people. Yes.

MS TRAN: A question around local initiatives.

MS CONWAY: Yes.

MS TRAN: And whether or not there are any of that link, people with mental illness who come to you to other, I guess, provide social determinate such as legal services.

MS CONWAY: Yes.

MS TRAN: Is that - - -

MS CONWAY: So what happens with us, our created pathway in the organisation is that we have referral systems off – that we – if we can't deal with the situation ourselves, which is normally what a lot of Aboriginal people will do, when people look at aged care services, oh, why don't aged care services want to – are coming into you know, having an aged care package, why aren't they – well, rah, rah, rah.

Aboriginal people tend to look after their own. And will take that on board hence over-crowding and other situations. So what we predominantly do at GRAMS through our Maga Barndi unit and how we support people is that we try and do it ourselves and then the pathway will go to outside services if need be. Legal services. Now, just really briefly, and for instance now, through Megan Krakouer, the boy that committed suicide here in the mid-west to two, three years ago, the 11 year old? Yes, the 11 year old boy? His brother - - -

UNIDENTIFIED SPEAKER: Brother.

MS CONWAY: Brother? His brother has recently been supported by an Aboriginal group called Ngalla Maya so we're – we met with the mother and the brother and other family members. They'd never accessed any other services after that boy's suicide. And what had happened was, they were in financial crisis three years down the track and what happened was we ferried him off quite gently with an Aboriginal worker from the Trauma and Recovery Project. Escorted him to Perth and got him into a pre-employment program and he's got all his tickets with the mines and is now working on the mines, the brother is.

But what happened was, if he hadn't have accessed our group therapy through the suicide support group that we have, then there's no way he would probably still be out there in financial crisis with the family. So that's what we do. We try and deal with – I suppose you can look at the Maga Barndi unit as the head of the octopus and then all the other tentacles there, they're the supports that we seek if we have to. Because more often than not, and we shouldn't have to, it's like a – I've talked to Amy and her colleagues as well, that sometimes because Aboriginal people have been – and services have been so used to be – so used to providing services on so little money, the shortfall is nothing, whereas maybe we should share as well and recognise that there's other service providers who would willingly be able to, you know, help the head of the octopus with its tentacles. So yes.

MS TRAN: Also, so in the report, we have a justice chapter as well.

MS CONWAY: Yes.

MS TRAN: So I was going to ask, do you work at all with people in correctional facilities?

MS CONWAY: I know that most recently, last year – last year or the year before GRAMS used to run the prisoner health program and we ran that for a number of years. We're currently moving into a social justice arm of GRAMS in our holistic sort of vision, but certainly we had the prisoner (indistinct) prisoner program. But the State for their better way or thinking had pulled all the funding from the two most successful Aboriginal prisoner health programs which I believe was Kalgoorlie and Geraldton, so pulled them and so everything went back to it being a state run program as opposed to a localised program which GRAMS had. We could have hung a lot of hats on that accolade they'd say. But yes, so the program was taken from us.

So, and this is what I mean about successful programs are continually, yes, on – so you wonder about whether or not the state wants the kudos from what's happening locally in the region.

MS TRAN: One more question. You spoke earlier about services needing to go towards Aboriginal and Torres Strait Islander people

MS CONWAY: Yes.

MS TRAN: But they aren't always accessing the services?

MS CONWAY: Yes.

MS TRAN: I guess my question is around how can we improve that act - - -

MS CONWAY: Engagement?

MS TRAN: Engagement and that access.

MS CONWAY: I know that most recently, I've spoken to Debbie about – that's our CEO, I've spoken to Debbie about the way that we engage with people ourselves and it – most recently we – yes, I think sometimes you have to take the theoretical approach and marry it up with what it is you actually do. Which is what GRAMS is doing (indistinct) moment, which is why I'm the community engagement coordinator, so across levels, how do you imbed that engagement? But I mean, I know certainly for other service providers, who may have Aboriginal people working with them, they're still representative of that group, do you know what I mean?

Just a quick example, I know that when I was working in the Goldfields and we had emergency relief as a program for people in crisis, Aboriginal and non-Aboriginal. And there were about eight service providers. And the conversation from FaCSIA I believe that at one stage, they were taking all emergency relief funding and giving it to one agency, the Red Cross.

So I said, what tipped me was that the head of the Red Cross at the time. So there was that conversation around – if you give it to one agency, which makes sense in terms of consolidated reporting and consolidated budgets. You think there's sense to that and my public service head tells me, that's why it makes sense. But anyway, that's a whole other conversation. But when you have agencies who are delivering services to - specifically to Indigenous people and who aren't doing what they're meant to be doing, and I have had a couple of service providers who have said 'We struggle with the partnership and the engagement. Well, our argument then is, well, previous to you putting in the tender, then mate, that should have happened. But where do we go to from here? Because you can't sort of dwell on something like that and it's how do you move forward and how do you put those steps in place.

So certainly, the methods of engagement, the design and the delivery of engagement. Even from Aboriginal services, I think, that needs to be looked at. Almost like a comms model. You know, taking into account how you actually communicate with people. I know there's the unsaid and the said with Aboriginal people, but certainly about how we help our non-Indigenous brothers and sisters and service providers to actually become part of our cultural framework and learn some of the more intimate secrets about engagement and what it is that we do for Aboriginal people. So yes. I hope that's answered your question.

MS TRAN: No, it has, thank you.

PROF KING: Thank you very much.

MS CONWAY: Thank you very much. And thanks for the opportunity.

PROF KING: Thank you. I will look towards Alistair. Has anyone said that they'd - - -

UNIDENTIFIED SPEAKER: (Indistinct).

PROF KING: I'll ask generally. So is there anyone else who would like to speak?

UNIDENTIFIED SPEAKER: Could I just add a comment?

PROF KING: Please come back. You'll need to restate name and – again, because it's all for transcript.

UNIDENTIFIED SPEAKER: (Indistinct words).

MS GREEN: So Claire Green from Elucidate, just a brief comment. So I think what stands out for me today being the two key themes is (1) that we need to do better in our training within our clinical models because what I'm hearing is that we're actually just talking about communicating with people and it doesn't matter what group of people we're talking about. Actually, a lot of the strategies for working with Indigenous people actually work far better with the average white person as well. And so I think in our training when we're talking about our models, we actually need to get down to how do we communicate? How do we foster relationships within services? And how do we get there on a person based level, so we can talk about person based care, but yes, we're all still saying that it doesn't really exist and that we need to build upon it in the wider sector and the wider system level. So I think that's really important that we get to that grassroots issue.

And the second, which actually Cathy brought up, I believe, is that we also need to address the elephant in the room and that in clinical models, sometimes diagnoses are stigmatised over other diagnoses and that sometimes suicides occur because it's not because people haven't said anything, but because the right people haven't listened and haven't fully understood what's actually needed. And I see that more in inpatient services where people are being discharged, not followed up and when they're stating and when carers are saying that there's actually a clear suicide risk and yet where still somehow happy as a system to let them go home and to balance that risk from a home environment setting and I just know of, in professional settings, where, because someone has got a particular diagnosis, a suicidal ideation has not been believed or substantiated all because they're stigmatised as a particular group of people or within a particular setting and I think that really needs to be clear on the table that we need the relational issues sorted above and beyond any extra system developments, so yes, just wanted to say that.

PROF KING: Thank you. Any other comments? Questions? People who wish to speak? One more? Yes? Again, you have to come down the front though to form - - -

MS STEWART: Fiona Stewart, just a point - I wanted to follow up on the other Commissioner's question to me if there's time?

PROF KING: Yes, please come down and again, you'll have to restate names on for the transcript.

MS STEWART: Fiona Stewart, headspace manager, Geraldton. The Commissioner on the phone had posed a question around what we were doing with Clontarf because I'd mentioned that as one of our programs under suicide prevention particularly for our community and there's a long segue into how it came about.

But what it was, was the long format relationships that needed to be built with those young men and Clontarf is – and we identified Champion Bay High School at the time, it was John Willcock High School as being inaccessible to the main part of town public transport system. How do you find – we'll go to the young people.

And in communicating with a whole lot of informed Aboriginal and Torres Strait Islander men in the community, Clontarf was put onto my radar as a seven years ago Victorian, we don't have Clontarf over there. Our three male clinicians, we began trialling one year with a clinician who attended every core meeting that that year seven cohort of young boys has. Every camp that they go on, every health day that they have and their meetings.

And it was – all it was to begin with was the consistent same person there, every single time. Mental health wasn't mentioned and in fact I instructed them not to mention that. And that relationship over a year was evaluated with the head of the Clontarf Academy and he said yes, I want it back. And I said, do you want another one? Year 8? Because I have seen the Steiner School system slightly and when you follow a cohort of people through and so our first clinician is now in Year 9 with his set of Clontarf boys and he said to me, 'Do you think I'll graduate with them?' And I said, 'If you're here, yeah, definitely. On my books, you'll graduate with them.' They go to their ceremonies, so we have a clinician in Year 8 and our third clinician will start in Year 9, so there'll be a continuous presence of our – and they're male.

Had to be male clinicians, will go through with those young fellows and repeat exactly what's happened with our first one and in the meeting I had this week with Justin Mallard and Bob from Clontarf, Justin, the head of the academy said to me, 'Fiona, you said you'd be there' – I think, not Fiona, but the odd – you know, you've done it, you've turned up, your staff have been there and we're seeing those rewards now. And I knew it would take years. I knew it would take years and the hope is, that you can't put a KPI on at all, is those young men will have seen Reto who is the first clinician through to Year 11 or 12. If something happens where it's really – the straw that breaks the camel's back and it's impulsive, because part of the view around suicide is there was an impulsive nature.

PROF KING: Impulsive, yes.

MS STEWART: They will stop, potentially have the skills, because mental health is mentioned and good health and yarning happens now that they know Reto after two years going into a third year, that they might pause and say – they might not have to come to headspace. I don't mind about that. But there are people who will listen. There's a possibility and so that support is a part of a default mechanism, is the hope, but it takes that overarching relationship and I just wanted that Commissioner to know.

PROF KING: I agree. Thank you very much. Can I thank you all for attending today? Thank you, in particular people who have come from some distance here. Some of you have

come from Perth, some of you have come from other parts of the mid-west. I will – and thank you to the staff as well. Thank you to the transcriber.

I will now adjourn the hearing. Formally, we will start again in Perth tomorrow if you haven't had enough and wish to join us.

MS ABRAMSON: Thank you. Thanks, everyone.

PROF KING: Thanks, Joy. Thank you.

MS ABRAMSON: Thanks.

**MATTER ADJOURNED UNTIL
THURSDAY 21 NOVEMBER**



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

PROF STEPHEN KING, COMMISSIONER
MS JULIE ABRAMSON, COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

AT PAN PACIFIC PERTH, 207 ADELAIDE TERRACE, PERTH
ON THURSDAY 21 NOVEMBER 2019

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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 be 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 CoMHW, 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 providing 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, anything 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 CoMHW 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 be 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 on 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 Headspace 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 DURINGTTON: So we do fund, we do commission some things where we provide the primary mental health.

MS ABRAMSON: Yes.

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

MS ABRAMSON: Yes.

MS DURINGTTON: 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 DURINGTTON: Yes, full stop.

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

MS DURINGTTON: 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 DURINGTTON: Yes.

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

MS DURINGTTON: 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 DARRINGTON: That's correct.

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

MS DARRINGTON: Really are, no.

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

MS DARRINGTON: Yes, okay.

PROF KING: So fantastic. Thank you very much.

MS DARRINGTON: Thank you very much.

MS ABRAMSON: Thank you so much. Thank you.

MS DARRINGTON: 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; I 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 with 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 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 the 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 build 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 momentum 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 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 bulk 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 employ 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 scale 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 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 be 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 MARKOVVS: Good afternoon.

MS ABRAMSON: Thank you. Would you like us to - - -

PROF KING: Would you like it to be a formal submission?

MR MARKOVVS: 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 MARKOVVS: 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 MARKOVVS: 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 - - -

MR MARKOVVS: Yes, we beat the bugger.

PROF KING: Good.

MR MARKOVVS: 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 MARKOV: 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 budgets 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 MARKOV: 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 MARKOV: 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 MARKOV: 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 MARKOV: Thank you, it's also passionate I think.

MS ABRAMSON: I think that's a good thing.

MR MARKOV: 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**



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

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

TRANSCRIPT OF PROCEEDINGS

WESLEY CONFERENCE CENTRE, 220 PITT STREET, SYDNEY
ON MONDAY 25 NOVEMBER 2019

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PROF KING: Good morning. Welcome to the public hearings for the Productivity Commission Inquiry into Mental Health. My name is Stephen King and I'm the presiding Commissioner on this inquiry. My fellow commissioners are Julie Abramson and Harvey Whiteford. I would like to begin by acknowledging the traditional custodians upon the land on which we meet today: the Gadigal people of the Eora Nation. And I would also like to pay my respects to elders past and present.

The inquiry started with a reference from the Australian Government in November 2018. We have talked to representatives from the Australian State and Tertiary Governments, service providers and (indistinct) unions, academic researchers and individuals with an interest in the issues and (indistinct words) throughout the inquiry. We've released issues papers in an issue paper in January and have talked with a range of organisations and individuals with an interest in the issues. We've received 573 submissions since we started the inquiry.

We're grateful to all the organisations and individuals that have taken the time to prepare submissions and who appear at these hearings. A few weeks ago, we published our draft report and the purpose of these hearings is to provide an opportunity for interested parties to provide comments and feedback on the draft report, facilitate public scrutiny of the Commission's work and to get feedback.

We would like to conduct all hearings in a reasonably informal matter. But I do remind participants that a full transcript is being taken. For this reason, comments from the floor cannot be taken, but at the end of the day's proceedings, Ms Abramson will provide an opportunity for anyone who wishes to do so, to make a brief presentation. This is the sixth public hearing for this inquiry following hearings held around Australia. And we're going on from here to Broken Hill, Rockhampton, Brisbane, Launceston and Adelaide.

We'll be working towards completing a final report, and having considered all the evidence presented at the hearings and in submissions as well as a way of informing discussions. For those planning lodge a public submission with their feedback on the inquiry, the closing date for submissions is 23 January 2020. And the final report will be submitted to the Australian Government in May.

Participants and those who have registered their interest in the inquiry will be advised when the final report is released by Government which may be up to 25 parliamentary sitting days after completion. Participants are not required to take an oath but are required under the Productivity Commissions Act to be truthful in their remarks. Participants are welcome to comment on issues that are raised in other submissions.

These proceedings will be live-streamed to the Commission's YouTube webpage. All participants who have registered here have confirmed their understanding that they may be visible or audible online. If anyone here has queries about this but does not wish to be visible or audible online, please approach one of our inquiry team members here today or feel free to leave here and now.

The transcript will be made available to participants and will be available on the Commission website within a week of this hearing. Submissions are also available on the website. For any media representatives attending today, some general rules apply. Please see one of our staff

for a hand out which explains the rules. If you do wish to speak, by the way, at the end of the day, and you're not down formally to talk, please let the staff know during the course of today so we can organise that. Participants should be aware that any media representatives may be using Twitter and other internet mechanisms to convey information (indistinct) in real time, including participant's remarks.

We comply with the requirements of the Commonwealth Occupational Health and Safety Legislation. You are advised that in the unlikely event of an emergency requirement evacuation from this building, there will be relevant alarms. I did have them explained to me by Henry who's up the back. And I won't say but it's – 'Woo, woo, woo', and then 'This is not a drill'. And perhaps, though we don't need to really be worried, there are escapes – exits over on the side there and out to the way that you came in. The evacuation point is in Hyde Park near St James Station.

If you are at any time feeling distressed we have psychological support on hand and Lynne, would you be able to – if there's any additional information that you'd like to convey, we have team members here who are happy to talk with you.

How we like to do these presentations or the hearings is if we have say, five minutes for an opening remarks or opening remarks from participants and then we will have question and answer and a bit of a discussion to try and get the key issues. We will often welcome parties to put in their submissions, particularly where, you, know, given time limitations and further hearings, we can't cover often all the issues that we'd like to discuss.

So that being said, I would now like to welcome our first participants today, Patricia and Andrew Anderson. Join us at the front table. And formally, for the transcript if you could state your names, if you are representation any organisation, relevant organisation or capacity in which you're here in and then if you have any other remarks, we'd like to hear them.

MS ANDERSON: I'm Patricia Anderson. We're here as parents (indistinct) minimal service and (indistinct) experience. So we had an – the issues that arose as a result of that.

MR ANDERSON: Yes, I'm – pardon me. I'm Andrew Anderson representing the patient's father.

PROF KING: And are there any opening comments you wish to make?

MR ANDERSON: Pardon?

PROF KING: And are there any opening comments that you'd like to make?

MS ANDERSON: What we'd like to say, that we hope that what – what we do discuss here today doesn't have a detrimental effect upon our – having our child here, because we still are entrenched in the system. The issues have been – we have – we were looking into this situation – well, we tried to obtain help for our son and unfortunately we went through the public system and private system, back to the public system and a path (indistinct) lead to corrections and now justice health, through that pathway. Recognised that there were issues that we thought led us to being – fall through the cracks.

And they're things that we think that need to be addressed at this Commission. The initial response that we had with a product – with the mental health tribunal after our child was admitted to an accredited institution, we weren't actually informed on what the tribunal actually involved and what our rights were.

The fact that our child was an adult, was used as a tool against us and that the decisions that he was making were actually led to him not making the best decisions in his (indistinct) also for ours. The Mental Health Act requires that the patients have agreed to treatment, but if you've got a person that you're caring for, obviously as parents, then we – we needed to convince the treating team (indistinct words) hospital that these decisions weren't made and that we did have the interests of our child in our best interest.

On the start of our journey we found access to the system quite difficult, going through a GP which meant another appointment and when you have somebody that doesn't believe they're ill, that's just another obstacle to counteract.

We ended up – to get help for our child, we ended up calling the police and ambulance and they responded appropriately and took us to the services that we thought that we thought that we would get the best treatment from for our son. Unfortunately, the nurses advocating in that service didn't actually happen, so we didn't feel that we were represented through the nursing system rather than the mental health system.

(Indistinct) obviously our child was discharged from that after a tribunal meeting and then we needed a readmission. We feel as parents, we – that should've been a red flag. That obviously a re-representation to a facility should have had some sort of significance and initiative about a response.

Unfortunately, our circumstances involved in an altercation that required assistance from police and ambulance in the early hours of the morning. And the first responders were good from our first call to them to their offering us assistance was eight minutes, which is a fantastic effort and we are obviously are indebted to those people, we need to protect those people so they aren't in any danger for actually helping. Following that, we ended up in corrections where our son's comorbidities – being a Type 1 diabetic, we didn't feel were addressed at that time, which leads to further ongoing issues once he is actually in the list.

So I think early intervention (indistinct words) is appropriate in the treatment setting and would show a more favourable outcome to the person themselves and the community as whole.

MR ANDERSON: Thank you. I'll be able to cover the points that Trish hasn't. Just so the Commission can get a bit of an – a better overview of her situation and we consider ourselves a completely normal family, three children, (indistinct) the kids doing very well at school, although Rich let's – in 2012 our son started to experience depression. He sought the help of a private psychologist and psychiatrist. He put him on medication. There were some improvements that his depression continued and he was recommended by the psychiatrist that he leave school at the beginning of year 12 which he did. And then we helped him get a job. So the next year or two was fine. He did discontinue his medication in that period and in the

middle of 2015, when he was (indistinct) out of home of his own volition, he got caught up with the wrong people.

And then in the – sorry – in October we found out he was using Ice and then in November, 5 November, we sought the help of police and ambulance to get him into high school. He was transferred to Bungarribee House, an acute care facility. In there, the first couple of days, he was mute, he couldn't even speak. We were communicating by drawings. He seen him drew, they put him on medication. About a week into that first day, we realised that his partner was bringing him home cooked muffins and we believe they contained Ice. We complained about it. They said it was permitted to bring him external food.

Now, the facility is a secure environment and I think to be fair to the treating team, there should be no food taken into a secure environment because it's interfering with that environment. They're losing some control. So you know, taking food into a premises like that should be banned in our, you know.

Moving on, David continued to improve. On his 13th day in there, there was a family meeting and when we arrived, the psychiatrist and the team had already met with David and then he met with us. And the psychologist said that he was going to recommend that he be discharged. And we were taken (indistinct) to that. Because we knew he needed longer. He wasn't ready to be discharged and so then the meeting was combined with David, his treating team and us. And he informed David in front of us he would recommend to the tribunal that he be discharged the following day. Really, as I said, we were totally opposed to that. We argued vigorously against it and I actually know (indistinct words) wanted to be discharged, so that was the beginning of the (indistinct) between our son and our self because he wasn't getting what he wanted.

So the tribunal happened on the following day, all the handwritten reports were – could be read by anybody. The Commissioner requested reports of the following day, we don't know what happened then. But he was discharged. David immediately stopped his medication on discharge and (indistinct) 212 days after the discharge which was 11 December, I got him back to a (indistinct) appointment. Without me taking, he wouldn't have intended. When I think Dave (indistinct) because of the sitting, sitting there at home, he seems okay but a little bit off. Got him to the appointment. Halfway through the appointment which they'd asked me to give attendance, his psychologist left the room, psychiatrist, I should say, left the room, came back, and then he stood back away from the desk as opposed to being near us, which I thought was a bit odd.

Our appointment finished at 3pm, 5pm that afternoon, the psychiatrist phoned me. He said your son is psychotic, he is a danger to himself and the public. You need to get him back here. I said to him, I only left it two hours ago. Why didn't you keep him there? He said, 'Because you were with him.' Is aid, 'How am I going to get him back there?' I said, 'I can't.' And that's 7 o'clock on Friday so Trish and I discussed the situation. Going into the weekend, we decided it was pointless because he'd been discharged against our wishes in the first instance.

So we kept track of David every day or so. He seemed to be coming okay and then on Boxing Day, I received a threatening text. So once again we called the ambulance and police to get David back into medical care. Because David didn't want to be there, he was angst against us

which I can understand. He didn't want to see us, so we couldn't visit him. Then on 4 January, we managed to get a visit. We managed to – we were escorted into the main common room of Bungarribee House and then David appeared. He circled us until the psychiatrist came – sorry, the Registrar. So the Registrar met with us and David continued to circle us and bump his chest. And I said to the – it was so hard to register. I said, 'Look at him? He's off his face?' He said, 'I'm recommending that he be discharged tomorrow.' He was not even put back before the Tribunal. I do not know why.

One of the reasons it might have been, because it's 4 January, whether they couldn't get enough staff to do it or not, we don't know. But once again he was discharged against our will. And he almost (indistinct).

At the first tribunal, I stood up. Trish and I were given our opportunity to speak. We both spoke and I clearly stood up and said, 'David needs help. Please send him to compulsory rehab.' So for the second time, you know, we were quite upset because of what had happened; we stopped sort of contacting David. And then on 22 January, the attack happened. So that was only 17 days after his second discharge and I won't go into detail, I don't think. But some of the problems as we see it – and look, I'll preface these by saying some of the staff we've experienced through the forensic or mental health system have been brilliant, they go above and beyond. However, however, some others don't even want to communicate with you. And for the ones who have helped us, we've got some (indistinct) for those people.

It's all the other problems and values that we see in the system, young mentally ill person is not capable of making a rational decision and yet they're treated as a normal adult, which they are, but they're not capable of making any sort of sensible decision. So I feel that some authority should be taken away from them. We, as parents, perfectly responsible parents, even though we were given opportunity to speak, it wasn't really considered what we had to say. And there's a definite imbalance there.

When we were leaving Bungarra House the first time on the last or second last day, I thanked one of the nurses for their assistance and help. And I said, 'I may not see you again' and so I thanked him and he said, 'I'll see you again', I said, 'Well why do you say that?' He said, 'David's not ready to be discharged, he should be held here for at least another fortnight.' So my point here is that psychologists and psychiatrists in the system, they've got a terrible, difficult task of assessing people. So I don't know whether there's enough weight given to the nurses, you know, who are spending up to eight hours a day with the patients. Whereas, you know, I think they should have a greater input in the outcome.

After David was discharged the first time, I received a call about 8.30 one night from the follow up person saying, 'David's not answering his phone calls, we've been to his house, there was no one there, can you contact him and talk to him?' And I said, 'Well, why don't you try and text him, he texts all the time?' I said, 'That's what young people do', and he said, 'Well we're not allowed to text.' And I said, 'Oh', and then he said, 'Well some people fall through the cracks' and I said, 'Well that's not good enough', I said, '(indistinct)'.

But anyway, nothing seemed to happen but my point there is, I think the system needs to embrace technology. Young people today they're texting all the time and apparently it was in the protocol that he couldn't text. I think people in the system who are known to be non-

compliant - because David had previously stopped his medication of his own volition, I think when they're in here the first instance they should be warned that once they're discharged if they fail to comply with the conditions like taking medication, I think it should be automatic re-admission, either by parents or carers who can call up or the treating team. They need that authority to say, 'Okay, you're non-compliant, you're back in the system.' If they were advised that up front, they'd be more inclined to be compliant, obviously not everyone is going to be, but they need to be more strongly encouraged to.

I think it may be a problem of the system is the Mental Health Act. A treating team can only hold a patient against their will for a maximum of 14 days. Now, it can take longer than 14 days to properly diagnose a new patient. That's from the literature I've read on the system, because there can be multiple illnesses coupled with drugs or it can be just be a by-product of illicit drugs. And they've got to be off the drugs for a certain amount of time before a proper diagnosis can be taken. So it's not fair on a treating team that they've only got the authority to be retain 14 days. Whatever the timeframe is, I don't know, but it should be something like at least three months or more before it goes to a tribunal.

I think, there needs to be more facilities in terms of compulsory rehab. We as parents we wanted to do everything possible to prevent what actually happened. We could have financed compulsory rehab but we had no legal way of doing it. It's impossible. The only possibility is if we'd broken the law, arranged kidnapping or something like that. Now, we can't do that. We were powerless, and we're not the only ones, there's lots of parents in this situation. But there is no facilities and we have to rely on psychiatrists, that's why they need to be given more authority, more power than what they have at the moment.

And when they arrived at our place on that night of the incident, the only reason I had him admitted is because I saw an opportunity to help him, we wanted to help. The system had turned us away. So we were left with ourselves to fight the battle, and we did, and it almost cost our lives. It shouldn't be like this.

Even now when David was found not guilty because of mental illness, he remained in gaol, put in corrections for 12 months. That is terrible by anyone's word. There should be a system - like they say he was transferred to other sections but gaol is gaol, there's no ifs or buts. The law should be changed, once a person is found not guilty, they should be out of corrections within seven days, and the government needs to find enough money to finance this. They can find it for the stadiums and what not. The system is opening, is over 168 hours per week. Stadiums are only used about three hours a week if you're lucky.

There's not enough beds in the mental health system and that's causing a backlog in the gaol. They're just held in gaol until they can get a bed. Now, even now, David's recently been approved to go to (indistinct) unit. But there's an approximately a six month wait, so that's more proof there's not enough beds in the system. And unfortunately today there's more mentally ill people than ever before but the funding is not matching the increase of mental health problems.

If the system was more proactive up front as opposed to reactive, we believe that our situation was entirely preventable. You know, we tried but it's too hard just with parents. The system has to support and that's - I've gone over the points. I really appreciate the opportunity and

thank you. Once again, we really appreciate those staff in the system that helped us. Thank you.

PROF KING: Thank you. Just a couple of questions.

MS ABRAMSON: We just want to extend the time to talk to you.

PROF KING: You've raised a large range of really important issues. I'm going to touch on one which is, I suspect, the hardest one from your perspective. Would (indistinct) difficulty or the right to be individual and the rights of the carers to care in trying to balance (indistinct). Now, I wonder if you've got any thoughts about how we can improve the system to make sure that – let me give a simple example. You were mentioning somebody who goes off their medicines so they're non-compliant, for a mental illness and potential actions that should be taken. That would be very different to what we'll do for say, a physical illness, so for someone who was a diabetic and there'd be the child and they're off their medications, they're eating badly, and you know that is going to lead them either in hospital or dying.

But as a society we make the judgment, well that's the individual's choice, so for a physical illness. For a mental illness obviously it's a much, much harder situation to be get that balance right. Have you got any thoughts about how we could change the system, is it a matter of independent advocates being able to be brought in by a parent who can evaluate the situation and who can say, 'Yes, the parents need to have responsibility for certain things here or not.' How do we deal with this because it is, you know, it's a moral dilemma that we're facing in our system and it's one that I haven't got answers to. So it'd really be very interesting hearing your thoughts?

MR ANDERSON: It comes back to my point where once their admitted to the system, I think the treating team needs authority to retain them longer to get proper assessment. And if mental illness is suspected, coupled with strong illicit drugs, they've got to be held in the system. There's just no other way around it because, you know, their system has to be cleared of the illicit drug and then they can determine whether there is underlying mental illness. And when there's a combination of both it's just a terrible situation.

So I know there could be overprotective parents but you've still got to keep these people in the system for proper assessment and there could be – you know, the tribunal could address that after three months. So there's still protection's there for the individual if the parents or carers are estimating the problem. But, you know, Trish has been a nurse and now a clinical nurse consultant all her life so she knows all about caring, and you know - - -

MS ANDERSON: I think there are a lot of services available but I've been to functions and they've said the funding stops after 12 months. So, if you're in this situation, mental health is a long term issue, it's not a 12 month issue. So you speak to the people that work in the NGO's and they say well their funding stops, they're staff start to leave at the end of nine months to look for something else, to go somewhere else.

But with our story, you can only tell it so many times and it's exhausting. You need to move forward. We're now from – from, you know, the courts through the corrections and now in justice health, and we're progressing that way. It's exhausting to keep going back to the story

of why we got there. It's about getting better, it's about moving forward, it's about support and there are lots of people that will support and advocate but there needs to be financial support for these people to know that yes, we have a job.

When you're approaching different services and you're redoing your story, it's just exhausting and you just stop because you're going back to square one, you know, and people want to know if you see a counsellor. Yes, you see a counsellor, the first visit is the story again, and then it's the next one, and then – well that person doesn't suit you, so you're looking for someone else and that's when you stop. The carers stop because you're approaching lots of people but no one can actually help you, and then all of a sudden you find someone that will and there are, you know, marvellous people out there who will connect you with people and will help and that's how I've gotten involved in the carers reference group at one of the hospitals and on the Mental Health Council, because we need to have something that is accessible to everybody, that there is equity in the system. You know, I don't think one story is any worse than anyone else's because everyone's struggling and everyone wants the best outcome for their family.

MS ABRAMSON: Mrs and Mrs Anderson, can I thank you for coming to talk to us this morning because it must've been a very distressing time and getting the real life experience of people really matters to this enquiry. So thank you for doing that.

I wanted to ask you a couple of particular questions. We've been thinking a lot about what Commissioner King just talked about, balancing the rights within family. One of the solutions is an advanced care direction which is correction which is when a person is well enough to make informed decisions actually executing a form which says, 'Well, my parents in these circumstance will be able to make decisions for me.' But given what you've said about your son, do you think that would've been any use to you or would he never have been in a position to give you that authority?

MS ANDERSON: I have been to talk with Carers New South Wales and that was bought up, to look at the power of attorney during power of attorney. But when you have a crisis situation, which we did, it escalated quite quickly, there was no – no time for that, you know. And to get legal people or professional people into – to the services is quite difficult. We were using Legal Aid initially and yes, they're overworked but the Legal Aid representative was hiding behind the door and didn't want to talk to me. You know, as parents, as carers, you know, we're – up until this event we were honest, you know, honest people, I had a speeding ticket, that was it, you know. And then all of a sudden you're thrust into this system that you're not familiar with and it's going on around you, you're involved in it, but you don't actually understand it.

MS ABRAMSON: I think the proposition is that you would do it not in a crisis situation, so just like with elderly parents, you might get a power of attorney administered. So that's the point of the proposals that we're actually thinking, that already there. So you would have that in a crisis situation. I guess my question was yes, within the crisis situation you're not going to be able to – the person is not well enough to give that direction.

The second thing I wanted to ask you and if you don't want to answer it, that's fine, is the mental health care that your son received when in the corrections system. Because the evidence given

to the Commission has been on a number of occasions that's the first time somebody actually got care, imperfect though it is. So what has been your experience?

MS ANDERSON: After time he was transferred to the hospital at the (indistinct), and the people were very caring and administering medication. But with comorbidities I don't – they're not addressed, as such, being a type 1 diabetic, that wasn't taken into account and the weight problem, and as well as the medications. It was, for him personally to be out of the criminal sector and into a hospital facility, per se, was better for him, was less stressful for him, and the people actually spoke to us more. We had more connection with the people in the hospital with the social workers, with the nursing staff there. Whereas (Indistinct) to corrections you're just thrown in ultimately. So, yes it wasn't but it was acknowledged and he was connected with psychiatrists and treating people that were actually addressing his needs.

MS ABRAMSON: Could I ask - - -

MR ANDERSON: But the care in corrections is nowhere near as good as the forensic system. That's why they need to be transferred, because the longer they stay in corrections, the worse they're basically getting. And to go back to your previous question, with that authority?

MS ABRAMSON: Yes.

MR ANDERSON: The problem is that the individual or the person, they think there's nothing wrong and they think everything is perfectly normal even though they're irrational or delusional. So they're not going to give authority, I don't think.

MS ABRAMSON: No. You actually highlighted one of the difficulties. It will work in some circumstances where someone has some insight into the illness (indistinct), and it will work in those circumstances. That's why I was pressing you a little bit because what you say to us is really important and trying to think through what a solution might be so that the family does have an ability to have their say and have their say respected. It's not just about you being able to talk, which you said the Mental Health Tribunal, it's about someone actually giving weight to what you said. As Commissioner King said, we've got to think through what we might be able to do there. Thank you.

PROF KING: Thanks for presenting today. I think one question I have, the delay in transfer from Corrective Services to Forensic Mental Health from your understanding was the lack of the number of beds in the Forensic Mental Health system?"

MR ANDERSON: Yes, without a doubt.

PROF WHITEFORD: Thank you so very much for coming in and sharing your (indistinct).

PROF KING: Next we have Rebecca Davies. Rebecca, if you state your name for the transcript and any organisation you might be representing?

MS BURDICK DAVIES: Certainly. My name is Rebecca Burdick Davies. I'm the director of policy and advocacy and government relations at Suicide Prevention Australia. For the benefit of the Commission and anybody who's not family with our work, we are the national

peak body for suicide prevention in Australia. We represent many of the largest not-for-profits operating in the mental health space as well as the smallest. I have a few opening remarks, if I may?

So first of all, I really appreciated listening to that powerful lived experience testimony that came before me from Mr and Mrs Anderson. I feel that their evidence has really (indistinct) the opportunity that we have here to get the system right. We feel at Suicide Prevention Australia that we've reached a watershed moment in history, (indistinct) we have the productivity commission's enquiry on the way, and we have the Prime Minister committed to reaching a zero suicide rate. We have the appointment of a national suicide prevention advisor, we have a Royal Commission into the Mental Health system in Victoria that can (indistinct) that this is – it's an unmissable opportunity to reform the mental health systems, and so we really appreciate your attention to this issue.

First of all, there was some key things in the draft report that we found particularly welcome. So the emphasis, of course, on whole of government collaboration was something that we were delighted with. I think it's an expression that might not be particularly meaningful for some people in the community but from a policy perspective it's extremely important. We see that the health ministers have agreed to execute an agreement, we hope that they will sign that agreement as soon as possible, a national mental health and suicide prevention agreement, and put it into action.

However, supporting that agreement we need to see some practical mechanisms to make that whole of government collaboration real. Things like, for example, a compulsory assessment of suicide prevention and mental health impacts as part of the cabinet's submission process, we'd like to see that at the Commonwealth level. We know that a couple of the jurisdictions, Queensland, for example, has already put that mechanism into place. We also appreciated the Commission's observations around digital technology and the opportunities that that presents to open up access for patients, particularly in (indistinct) in rural and regional locations.

What we do hope is that the Commission will turn its mind to the full opportunities of digital in the 21st Century. So, digital is not just a mode of delivery, a mode of connecting clinical support services or real life clinical support services with a patient. It's also, you know, a platform in and of itself, so you only need to look at, for example, ReachOut's platform for young people to see the possibilities that digital presents. I think Mr and Mrs Anderson, actually made an observation that their son would have benefited from access to digital means of obtaining support. So I thought that was a really interesting case study to underpin that example.

The emphasis on after care, so speaking from Suicide Prevention Australia's viewpoint, after care is absolutely critical and it's something that we find is particularly patchy across a number of the jurisdictions. Victoria is doing some fantastic work in this space. They have – the full name of the program is the Hospital Outreach Post-suicidal Engagement initiative (HOPE). It's been trialled in some locations in Victoria. We need to see a national scheme of this nature. We all know that or the Commission would be aware that the people at greatest risk of a successful suicide attempt are those who survived a first attempt. We need to follow up with them closely in the first three months at least, after the first attempt has been made.

There are also a couple of things that we felt were not touched on in the recommendations, although they were of course considered in the body of the report. The first is, that we hope the final report itself provides a very clear road map with clear signposting for government to take up. We feel that has been missing from previous enquiries of this nature. The World Health Organisation, of course, has been recommended for years, the three pronged model, one which comes up with a strategy for the population level to address equity and social determines. Community level strategies to improve social inclusion for priority populations and then individual strategies. So we think it would be particularly useful if the final report were organised in that way.

Data, you may have seen some (indistinct) media reaction and public commentary on the report. But we really do hope that there's some strong recommendations around data in the final report. We can only improve the services and the program (indistinct) programs out there in mental health and suicide prevention if we can measure their efficacy. We can't do that with patchy, fragmented information that's out there at the moment, particularly on suicide. We only, for example, have two jurisdictions, Victoria and Queensland with a suicide deaths register. That has to change.

Another thing that we would like you to consider is the whole issue on workforce planning. We've heard today, for example, that some people in the mental health system are very highly skilled, very caring, very well-equipped to deal with the situations that they're presented with and we also know there are significant training gaps. They're also in the informal suicide prevention and mental health workforces. So we have a range of clinical services available. We have a range of health services available. But we also have other touch points in the community for people who suffer from mental ill health and who may be at risk of suicidality or taking their own life. We need to (indistinct) to those people as well.

Coming up with a workforce strategy of that nature, we know would be a task of some years. That's why we would also like to see investment in some practical scalable measures that quickly delivered in the next year or so and they would really address those urgent gaps. From those, for instance, we believe that training for clinicians and emergency department workers, there needs to be a concerted effort to upskill them. For example, we know that only 14 per cent of paramedics have appropriate mental health training. So appropriate training to respond to someone with a mental health crisis.

We also know that a casual conversation can change a life. For people living in rural and remote communities, a lot of those conversations happen with their local pharmacist. In New South Wales, we've seen a small scale of investment of a million dollars invested in a program to deliver first aid in mental health training for pharmacists. We would love to see that initiative rolled out across the country, pharmacists really are regular touch point for people out in the community and often a friendly conversation can turn into an opportunity for something later, for direction to support services.

Finally, we think there's also an opportunity to ensure that all the public money, all the investment that we've seen put into the mental health and suicide prevention systems is delivering a return. And a return for the tax payer and government really means that the services and programs invested in are high quality and that they deliver outcomes. And from a suicide prevention perspective an outcome is a reduction of the suicide rate. We believe the

best way to ensure this happens is by putting in place a national sector led accreditation scheme, similar to that, that we see in other industries. It's something that we will be expanding upon in our written submission, which will be of course made by 23 January but we think that that would be a very important way of really lifting the standards in the sector which is something that we have heard through your hearings, is a problem

PROF KING: Thank you. A number of issues there, my colleague might touch on the (indistinct) scheme but I might leave that, as you said you would be putting in another submission that touches on that. Let me go to workforce initially, one of the issues that's been raised in some of the other hearings is a lot of the community services are provided by the not-for-profit sector and non-government organisations. We've heard already this morning the issues of the (indistinct) contracts and (indistinct). We've also heard, similar to what you said because they're often the touch points for people's mental ill health. That there needs to be more of a workforce strategy, more upskilling of that workforce. Our report goes into some detail about peer workers but not generally into that sort of strategy for the NGO workforce.

I mean I guess I can see some benefits, I can also see some issues. The NGO workforce, in a sense, it's not a high paid profession. It's got low sustainability in the sense that they are surviving on short term contracts and you suggest that they get extended. But putting peer workers to one side, because I think that's an incredibly critical part of it. But for other workers in that sector, what do you actually see as being the relevant upskilling, and is there a risk that by doing that you actually end up with fewer people working in the sector because simply it's (indistinct) hard to get that - - -

MS BURDICK DAVIES: This (indistinct). Okay, so when we talk about upskilling, we're not necessarily calling on government to focus their attentions on people who are already trained as, for example, mental health nurses or psychiatrists. We're talking about people operating the public health system and also outside the public health system who are a touch point for people with suicidal crisis. I don't believe that providing basic mental health training or suicide prevention training, for example, would involve identifying the kinds of words that someone might use, that express that they were in a crisis.

I don't believe that that would necessarily be a deterrent to someone seeking entrance into the workforce. I think there's a broader problem which you've really touched on, which is the fact that there's insecure forms of employment in the whole sector. We need to see funding certainty, we need to see governments committed to, for example, providing three or four year or longer term funding streams, so that people aren't at the mercy of (indistinct) contracts. That's what we see as the biggest issue there. But with the whole area of upskilling people outside that formal suicide prevention workforce, we see that those people (indistinct) benefit. If you're a pharmacist in Bourke, for example and you have someone presenting to you who is obviously expressing some issues with mental illness, that person, that pharmacist would feel far more confident in engaging that conversation if they're provided with the appropriate skills and training.

PROF KING: Thank you.

MS ABRAMSON: Thank you. I wanted to ask you about data. We're very interested, as you would know from our previous work in data. So what sort of data were you thinking of and

how would it be used? And I guess the corollary is with data, always worrying about the rights of the individual, the privacy but also the public benefit that might flow?

MS BURDICK DAVIES: Of course. That's really important to strike a balance on that point. I mean, you would be familiar that there's a couple of strategies on the information management side that you can engage in such as the (indistinct) data of there, the application of data that you might - - -

MS ABRAMSON: Yes.

MS BURDICK DAVIES: - - (indistinct) private concerns. The sorts of data pieces that we're looking for, number 1 really covering social determinants, so social determinants of health more broadly and suicide in particular. It's such - I think resolving in I think policy makers see that as such a bigger problem. If we have data on what those social determinants mean then we can actually - I think that excuse is taken away, we have to see some effort to resolving them, so, for example, you talked in your recommendations around increasing the availability for empowerment to (indistinct) this social determinant issue. So we need to see additional data on that. That can be by extending the national mental survey so there's an opportunity to expand that into the area of social determinants, particularly for priority corporations. So I think there's been a discussion around Aboriginal and Torres Strait Islander social determinants, explained in that space. And then I think also mentioned the fact of the issue of the suicide death registers in the jurisdictions. I understand that the Commonwealth Government doesn't administer those.

MS ABRAMSON: Yes.

MS BURDICK DAVIES: But it could be an opportunity - there could be an opportunity to tie that to the national agreement. If we don't have a suicide deaths register in every jurisdiction then we have no opportunity to really measure why, who, where suicide deaths are occurring, and we can't really tailor policy making in the way that we need to.

PROF WHITEFORD: So just staying with that point, the suicide death registry, one of the concerns that's been raised with us is the determination that the death was suicide and often that needs the coroner's involvement and that results in delay in recording the death, and the year it occurred, et cetera. Have you got any comments to make about how that could be improved and how you've seen it improving over the years?

MS BURDICK DAVIES: Yes, I think Vitoria has done some really good work in that space, particularly with the timeliness of the way that the coroners are conducting their investigations. I think it's something that we will have to expand on in our final submission. We are in conversation with the New South Wales Government around their suicide deaths register introducing a suicide deaths register here and I think I need to do some more analysis around what the barriers to that might be.

PROF WHITEFORD: Okay. So from what you're saying it varies from state to state about how well they're progressing that.

MS BURDICK DAVIES: That's correct. Yes. And there are only two suicide deaths registers

right now, Victoria and Queensland.

PROF WHITEFORD: The second question, so going back to the issue of training one of the, I guess, concerns and even criticisms that we've heard about mandatorily introducing suicide risk checking in assessments in peer departments or wherever the person might present is the tick box approach where it might be, Yes, here are the questions you asked, and you ask the question, you get an answer and, yes, that's completed. And I guess it seemed to be perhaps ineffective in assessing the suicide risk. Has there been any thought given to any standardisation or examples of where that's worked well or where it's been improved to the point - - -

MS BURDICK DAVIES: Yes.

PROF WHITEFORD: - - -where you believe it's good practice.

MS BURDICK DAVIES: So I believe in Scotland they rolled out - it wasn't a training regime of the scale and scope that we're proposing but they did invest in some training outside that, as I said before, mental health workforce. I understand their suicide rate has increased over the past year, but in the decade prior I think they were one of the only developed nations to see a really significant decline. Yes, I think Scotland is one of the jurisdictions that we'll be looking to and we'll be emphasising case studies from Scotland in our final report as well. Japan is another jurisdiction I think where they've invested in training. I think that's primarily been as part of their whole government approach, so people in the department of welfare and other departments that might touch on or engage with people who have - who are at risk of suicidology, they're being provided with some level of training, so we'll be looking at their results as well, the case study as well.

PROF WHITEFORD: Right. Thanks very much.

MS BURDICK DAVIES: Thank you.

PROF KING: Thank you.

MS BURDICK DAVIES: Thanks very much.

PROF KING: Next Associate Professor John Allan. And if you can state your name for the transcript, organisation you're representing if any, and then any information.

DR ALLAN: Thanks very much. Good morning, my name is John Alexander Allan. I'm the president of the Royal Australian and New Zealand College of Psychiatrists. Thank you very much for inviting me. Can I just start by acknowledging the traditional owners of the land, the Eora people, and pay my respects to the elders past, present and emerging. And also can I just acknowledge people with lived experience of mental illness and particularly their families and carers as well.

So thank you for inviting me to speak. The Royal Australian and New Zealand College of Psychiatrists is the body that represents psychiatrists in this country and New Zealand. There are 6600 members of which 4900 practising psychiatrists and about four-and-a-half thousand

of those are Australian. And there's 1600 registrars in training psychiatry (indistinct) representation of psychiatrist training and I speak for those people. We think there's no better health specialists who are in a position to provide advice. We gave a submission earlier which based on extensive consultation with our members, but I might rehashed that, and really just to say formally that we really welcome this opportunity. We actually agree that this is a once in a lifetime opportunity to make some changes. I'd like to talk about some of those. What particularly concerns us that people are living with mental illness in this country often have very, as you know, very fragmented services. We're particularly concerned that about half the people who have serious mental illness either have no services or inadequate services.

We gave a submission recently to the New Zealand Mental Health inquiry noting that (indistinct) the five per cent. There are five per cent of people in this country who have a serious mental illness, some people who (indistinct) with psychosis and bipolar disorders that includes people with some quite serious personality disorder, anxiety disorders, depression, and other childhood conditions as well. And we're quite concerned that access for those people, the fragmented system and quite a variability of treatment and all the things that you've heard, so we're really quite concerned about that.

We're very encouraged by your recommendation of the multi-sectoral approach. We feel that that's very important and many of the recommendations we would endorse. I think our main issue is with the complexity of the system and how far the reform is going to go. So we would endorse the establishment of regional commissioned authorities. We know that there's significant (indistinct) issues that (indistinct) governments, around the consumer, the care and welfare and is yet to be determined, but also we're concerned about the separation still of Medicare funding and the other funding, so that we're just wondering how an integrated system would look around that and have some suggestions that might help around that, particularly as 50 per cent of our members are actually involved in private practice so there are issues around performing work in public and private practice that we would like to know, and we hope that whatever it is doesn't just give us more of the traditional funding silos.

So we're also quite concerned that the system is (indistinct) crisis and that although we support the introduction of that that it might need to be trialled instead of regional - although metropolitan areas first, because we're just worried about that high level of change, and a good example of that was the moving of funding for PHNs, a very good effort and a lot of hard work by PHNs, but we've had many flowers bloom by the variation and capacity across the country, so those issues about what's centralised and what's local are particularly important for us.

We're also very concerned about the current mental health workforce to be able to meet the demands and you've flagged those points about disparity in distribution and so on. But we think that you've made some recommendations about more psychiatrists, and we'd invite the Commission to help establish a benchmark of a minimum number of psychiatrists required to offer an integrated system as well as looking at benchmarks around beds and community based services, and we know the national (indistinct) framework which is not accessible to all of the players in the is part needs to be accessible. We note that it's - we can talk about that, but it's also professional agnostics, so we need to sort of think about the roles of people in that, but it's a good place to start, but obviously it needs to be made more available and we can talk further about that, and particularly the training that will be required so that we can use that responsibly rather than using it for any kind of malicious purpose.

Also we stress it's just beds it's about community based services. We also note in the report some talk about physical health of people with mental illness and we actually know that people with serious mental illness usually they die 15 or 20 times earlier and that's right throughout the system but of course it's also the effects of diagnostic overshadowing, failure to get treatment for cancer and so on. And also that if you look at the mental health aspect of many, many people with chronic conditions they're actually quite severe, so it's also a challenge because the report recommends the integration of physical and mental health services, whereas it also recommends a separation of funding for those two, so obviously there's a challenge in that as to how we would achieve both of those aims, and (indistinct) to the future.

Also very supportive of the availability to Aboriginal Torres Strait Islander people effective self-management and how we might well do that through those organisations. Particularly we would like to increase the available Aboriginal and Torres Strait Islander psychiatrists who I think have a role to play for us.

And overall we think that the professional involvement of governments in decision making on both sectors, the public and private, needs to be regained. We think that there's a lot that's been lost by not using professionals to enhance the planning as well as the (indistinct) governance, so we'd like to see that. And obviously we're making a more detailed response to a number of your questions and recommendations further, but I'm happy to take questions on any of that.

PROF KING: Thank you, Professor. Let me start off, you said your organisation has some suggestions for the issue of the separate funding problems, for Medicare funding, and we've got other funding, grant based funding, block funding, activity based funding, funding under various approaches, and you had some suggestions for avoiding or perhaps bringing those together. Can I get your suggestions?

DR ALLAN: Sure. So there are many and varied, all right. So some of those are around increasing the number of psychiatrists and dealing with (indistinct) distribution and I'll come back to that if you like, and (indistinct).

We also note that the Medicare funding and, particularly better access, but also the direct access for doctors is quite poorly distributed. We wondered if the RCOs might not be able to think about that distribution and we suggested that there be a weighting of population in terms of the way the funding is used. Then they be - (indistinct words) are very good more in the sense that it gives a person certainty about seeing a doctor and that relationship between the doctor and the patient but also aspects about contracting that might be useful as there (indistinct).

There might be issues around incentives that we talked about being able to use the psychiatrist, not just on a one-to-one situation but to be able to (indistinct) across public and private. The other offers supervision to other providers for psychologists and other allied health professionals, to team with the mental health nurses to actually provide someone with serious mental illness (indistinct) to public or private so being able to team those people and to provide private service for a person with a serious problem which could be either NDIS funding, their medical services and their personal (indistinct) health might be a really good model.

In terms of effective in-base funding I think that's the next question, because obviously with

growth in mental health services, services rely on the on the (indistinct) to actually help with the increased demand whereas I think you've made the point that by funding always that way there's the incentive to continue to do it best. Our experience would be that in the public sector the pressure on the acute beds are so high that I don't think anybody thinks just about (indistinct) again with funding, I think they just think about demand, and so the first incentive is about the funding of the things in the community and the alternative to those hospital admissions, so obviously we note that we've got 50 per cent of the (indistinct) beds that we need, so there's a whole range of things that need to change.

PROF WHITEFORD: Thanks Dr Allan. So just coming back to the issue of training, one of the things we've heard - actually I'm sure the college is familiar with this, that a lot of the training is done in the public hospitals, and there are therefore constraints around the skill base that registrars may get trained in. Is the college able to suggest ways which we could broaden the type of training that psychiatric trainees are exposed to and then - - -

DR ALLAN: Sure. So around 170 of those training places were in the STP or IRTP the specialist training pathway.

PROF WHITEFORD: Can you just - so - - -

DR ALLAN: So that's a federal funded program that provides money for registrar to train in places they would not normally train, so out of the public hospital high volume system. So those can either be in rural places, for example in rural/regional Australia, particularly in remote and indigenous communities. They've also been used in lesser used specialties so in areas like a brain injury, neuro-psychiatry, perinatal mental health and also used in private hospitals for training so there's been some settings in the private as well.

And recently we've been able to focus with those particularly on rural training, rural and remote training, however we would - and that's been great and really, really appreciate that. But we also recognise that there are other areas in which that can be used, so for example in private practice. It tended to be used in private hospitals under supervision, but they could be used in large private practices as well. There's some issues around item numbers for registrars to provide and item numbers for supervision that could be changed around that.

There's also issues around payment for psychiatrists for the supervision that's required. A recent example that's really useful is that we've redirected with in conjunction with Department of Veteran's Affairs five of those places to be particularly in military oriented places so we're actually opening up psychiatry training places in military bases and in military hospitals that hadn't been there before to address the shortage in needs of psychiatrists for veterans and military psychiatry. So with a targeted approach like that we can actually open up a whole different field.

The problems with those have been that sometimes the funding hasn't been sufficient and then the costs of - the private institution that have been providing that so that needs to be reviewed. And there's been (indistinct) but they've been very successful. They need to look at that. So they need to do that. And the other one is that, as you know, with the public hospitals the pressure on work, the pressure on workload is not what it was when people like I trained in 20 - 30 - 40 whatever years ago and I think (indistinct) that supervisors don't do that same amount

of time devoted to teaching.

How people deal with that experience is not exclusive as it used to be, so there needs to be some different ways of funding for supervision and different ways of funding the training experience that would be more suitable to get that more balanced for psychiatrists. For example different if a psychiatrist need to be trained in psycho-therapy there is a time in the public - in a very busy public system and they're not (indistinct) with the training in psycho-therapy to do that, but if you think about the way that we need to treat them with anxiety and depression and other serious disorders that psycho-therapy training is the backbone of a lot of that psychiatric work, so we need to have new models to provide that as well and that might just imply higher supervision using supervisors from outside similar to the indigenous people we, you know, therefore would use cultural guides to provide that supervision in the services and so on, so there needs to be that range of different experiences and we've got to prepare people for this world, not for the previous world, they need to know.

PROF WHITEFORD: So could we just follow - one question on that, so has the college got any views about the different ways we could fund that training so that we could get the balance right but also given what you've said about the pressure on psychiatrists who work in the public system and their lack of availability to do the training that they had done maybe in the past, have you got suggestions about what we could look at to commend - - -

DR ALLAN: So, look, I think that the expansion of the STP and IRTV system is really very important because that's (indistinct) so you could increase that now and deal with that. The number of training places for psychiatrists have been limited by the fact that the funding to the public health systems has been limited so it really (indistinct) in other places. So that general increase in funding would increase the number of places, and particularly if there is a shortage like child adolescent psychiatry is a bottleneck in training and yet we need more, we need more perinatal infant psychiatrists because there's a whole push that you have suggested around early years requires those psychiatrists to deal with the training aspects but also with the treatment at the severe end. So there's that general increase in funding that we might need to have, those STP places are cheap for what you get, 100,000 - 130,000 per place per year is quite - you get good product. Some Medicare revisions to allow item numbers for those registrars working in private practice, because they're actually seeing the patients and working under supervision through that work, so it's a good investment to allow (indistinct) private health insurance and so on as well, so that you get a better scope.

PROF WHITEFORD: Does the college allow online supervision of registrars?

DR ALLAN: So it does allow online - well, video conferencing and online supervision (indistinct) rural and remote places, and I've done that kind of work for registrars in that space. We do, however, recommend - we do actually require that some of that is face-to-face, and so that's a combination of the person flying to those places as well as being online and telephone and email correspondence. So we do that. I think funding more of that so there's opportunities to tell the psychiatrists about (indistinct) make recommendations about the item numbers.

We would have some concerns that (indistinct) suggesting. You're going with the - what the Medicare Review suggested, which is why we have one particular item number in favour of (indistinct) that were the sum of that extra funding for setup and the extra work that's required

to (indistinct) and we'll write more about that in our submission. But telepsychiatry is another good way of allowing for that supervision, but there's also face-to-face.

PROF WHITEFORD: So just finishing up on training, so the training provided in the public hospitals by the consultant, I guess that time traditionally has been paid for by the state government, and what you're suggesting is that if there was an item number that could be involved in training in the fee-for-service MBS paid system, that would shift some of that training cost to the Commonwealth government?

DR ALLAN: It could shift, but I think that you have to acknowledge that the payments incurred by the psychiatrists is not just of their work time. It's outside work time, it's weekends, it's lots of other voluntary work. So we really run a training system based entirely on voluntary labour, and even the private system generally (indistinct) voluntarily. So, we've just reached a point of professionalism and volume where there's a need to have stronger supports.

And it's also the structure around training, so that just organising that requires considerable secretarial and administrative support. So we have the state governments support training through directors of training, and they've been reasonable generous. But there hasn't actually been an increase in some of that in some states for many, many, years. (Indistinct) has been some additions, but it's often been quite a pressure. And so that means that the whole thing that's required to mentor and bring those people through is - is quite stretched.

There's also some issues around whether we should need to train psychiatrists for everything, or whether we need to work with our other (indistinct) colleagues and trainers. So we've been talking to the (indistinct) medicine, to the Australian College of Emergency Medicine about certificates and diplomas that we might share, that would - that intersect in that kind of work and they can be used for training in both colleges for GPs, for that matter.

PROF WHITEFORD: How much does the registrars themselves contribute to the cost of their training in psychiatry?

DR ALLAN: Well, they give of their time, they give of their study, they give of their work. They pay fees that provide some recompense for some of the courses that they have. That varies across the states, so there's a formal education process which is like an afternoon a week of learning and lectures and so on, and they pay varying fees from one or two thousand to 10,000, \$12,000 a year on that, and they pay a training fee to the college of around \$1,000. They pay to sit their exams. Often that can be recompensed through their work, but they pay (indistinct) as well.

PROF WHITEFORD: Last question, sorry, is about the commissioning authority. So you gave some comments that you have views on that.

DR ALLAN: Yes.

PROF WHITEFORD: Clearly, that's a major recommendation, that the draft report's been made to deal with some of the concern, in fact, a lot of the concern we've heard about the fragmentation in the community mental health service sector, more broadly defined. It's an area which I think, as you've suggested - the college suggested is challenging. Have you got

any further comments you'd like to make about how that could work to overcome the silos, which is a criticism of the way the fragmented system exists in the community.

DR ALLAN: So, I think this has been a sore on the side forever, since the first national mental health plan. The last plan went some way towards joint planning, joint commissioning, and eventually joint funding. So we're now three years down from that plan, and although we've got some joint planning, we have limited joint commissioning and we have no real joint funding. So the question is, yes, that's a great ambition, but when would that ever be achieved? I think that's the issue.

So surely this joint commission authority could achieve that within our lifetime, rather than some other (indistinct). So I think that's the major reason to support it, because everybody is frustrated by the two tiers of government, and if you ask 90 per cent of practicing (indistinct) the split is just hard to navigate, just in every turn of - turn of the wheel. The different funding models, the different commissions, the different rules.

So just from that point of view, we think that that's necessary. And then it comes down to how far do you go with that. If you're really going to go with it, you need to go with it all the way. But we also have systems that work reasonably well in terms of private practice and (indistinct) service. People get to see the doctor they want, but there are delays. You've talked about how do we deal with those delays as well. We've consolidated within the private practice about those delays.

But we think there is just that opportunity for the different models. Workplaces are underserved. You've talked about being able to use different kinds of contracts and different arrangements, and different working together teams, those commissioning opportunities might fill some voids. We're just excited by the thought that it could be (indistinct), and I think that's really the truth

And we'd like to see a bit more detail, because what does worry me is that this is not just about the funding. The big issue is about clinical governance. So who actually has responsibility for the patients? If something goes wrong, who is actually responsible for that care? Working in the public health system, we know that there's a clinical governance system which will eventually look at problems, disasters where people die, and what should be done about that. That's not so clear in that blended system.

And so, we are very (indistinct) we want to make some strong comments about how that is likely achieved, if you're very concerned about quality care and patient safety. However, we also think that if you employ the best people with the best skills to do that, then surely we can set up a good system of quality and safety.

PROF WHITEFORD: Thank you.

DR ALLAN: Thank you.

PROF KING: Next, we have Dr Angelo Virgona. Dr Virgona, if you could state your name, what unit you're representing, and any opening comments that you'd like to make.

DR VIRGONA: Thank you. I'm Angelo John Virgona. I'm the chairman of the NSW branch of the Royal Australian and New Zealand College of Psychiatrists, and I'm really grateful for the opportunity to represent the 1,200 psychiatrists and 400 registrars in NSW this morning. Unfortunately, I'm following on from John and - which means that, you know, I haven't had a chance to redraft my presentation. But I'll read from it and you'll get a sense that we're all sort of speaking from the same page, really.

We commend the Commission in NSW on the comprehensive body of work that you have provided to us, identifying the major weaknesses, inconsistencies, and fragmentations that characterise mental health service delivery in this country. It's identified the impacts of a poorly functioning, dysfunctional mental health sector on society as a whole, and we support the contention that this isn't a health only issue. We agree with what's raised by the Victorian branch in their - in the hearings and their submission last week. I saw those, and obviously, with John's presentation this morning.

Really, there's this sort of consistent theme that we put in our original College submission about not enough of anything. There's really not enough of anything in the sector, and that has to be addressed. But it's not going to be able to be addressed without fundamental redesign of the system. We were quite excited when we read that you supported the rebuild option for the structure and function of mental services in the country.

The system cannot be renovated. We've had national mental health plans that John noted, commissions, recommendations from various state parliamentary and other enquiries over decades, and these have generally been futile reform exercises. We don't blame those organisations. Their frames of reference have been narrow. They usually end up asking for more money to fix this or that bit of the sector, which usually falls on deaf ears, or gets funded in time limited ways, or it's another poorly funded layer to the sector, confusing it further.

And within the mental health sector, we are really as functional a family of services with multiple players. We all mean well, but we take offensive postures, protecting our own turf with little appreciation for the role of the other players. As well as between major bodies, it occurs within our organisations.

As a fragmented sector thing we've had no success in achieving meaningful reform and we're desperate for a coalition of the major players. There is now the site for change, as you've obviously realised during the course of your consultations.

I represented the college at a national meeting of all the PHN's in May this year. Every major mental health organisation in the country was there, as well as the VHM's of course. In the afternoon, I chaired a session and it was on the implications of the productivity commission inquiry. It was an extraordinary meeting. It was the best attended of all the sessions there because people sensed that this inquiry was our best chance of change for a generation as everybody keeps saying.

We said it in our college submissions to you and he's been saying it for a long time and I am saying it today. I mean, and you said it in your report. The passion and commitment of all the players in that room there, was obvious. All agreed the system was broken. We needed a

blueprint for the future and that there had to be coalition of voices speaking with a single voice that we were going to influence government.

I was at a recent meeting in August of all the state and territory branches of the college and it was agreed that the rebuild option was best among that group. There was also an agreement I think that – for anyone but the Commonwealth to run it in terms of the approach to governance, given their track record in operational management of service delivery.

We also raised the suggestion of states and territories establishing and operating the Regional Commissioning Authorities. But as you pointed out also in your report, they can be wasteful and inefficient with, you know, I think one of the stats mentioned was a 20 per cent of the community staff members times in direct patient context and they have ridiculous demands for providing data and activity reporting.

And for those of us who have been around a while, the history of state-funded mental health care features pilfering and neglect of service development times, attempts at quarantining medical budgets and (indistinct). So that's just a word of caution on that front.

The college branches, before pooling funds, and the notion of the Regional Commissioning Authorities - but there seem to be a failing to consider another serious claim in the sector which was the private sector or the private hospital sector as well. I mean, they are a major player in the mental health service delivery in the country and they have significant operational experience. Full stop. I mean, I don't know if we will talk about this further, but the idea of triumvirates if you like of people of groups that tender or running Regional Commissioning Authorities should be something is considered providing private, public and community management organisation representation. Like John said, you don't want to commission some commission or model without it being tested and then vis-à-vis an identification of options and then trialling options in various sites being metro, regional and rural.

You've also mentioned there John, the issue of maldistribution of MBS rebates. You said in your report, the size of each RCA's funding should be linked to the body of MBS rebates for Allied Mental Health care in their region. But rather than that happening, I think that MBS rebates for the country should be totalled and distributed according to population.

In other branches of medicine, doctors go where the funding is. If a young surgeon wants to work as one, he won't get enlisted to an inner urban hospital when he gets his letters. He'll have to travel to an outer-metro area where the work is available. So it should be for MBS rebates in psychology and psychiatry.

I was going to talk about place and journey and how the development of Regional Commissioning Authorities would enable simpler points of entry or simpler points of entry into sort of into mental health services delivery. The fragmentation of the system gives the impression of good mental health care as a complicated exercise. It isn't necessarily. It requires the right resourcing and the right paths for the patient journey if we are to avoid the step-gap model which characterises the current system.

The pointy end is at entry. The primary care centre has a few problems as you noted in your report. It's not funded to provide comprehensive mental health assessments and the percentage

of GP's if you're confident about doing same is not high. Of course if there are proportionate GP's who can perform sophisticated psychiatric assessment and are comfortable with managing mild to moderate, sometimes in a psychiatric facility – they're in the minority.

Most others are comfortable with assessing mild forms of disorder and comfortable prescribing anti-depressants. Now, taking further steps along treatment algorithms, I agree with you on most of them. We expect too much. Also, many GP settings particularly on the outer-metro areas where I've relied on my Turbo Medical Seven model, and the relationships with the one GP are infrequent in these settings and time is limited.

As you noted, many people have conditions too complex to be treated by a GP. Excuse me, a minute, I just got a fly in my throat. No, no, it was a real one.

Pouring more money into GP education and training has been done to death over the years. Anecdotally, I and my peers have been doing GP education sessions for 30 years. The usual suspects turn up, those with interest and skills in management of psychiatric disorder and they are in the minority of general practitioners. Your suggested solutions to fix the MBS so that they are remunerated appropriately to devote time to complex presentations is reasonable. But there are question marks as to whether that will lead to change.

Access. The first point on the journey for a patient is access. It must be easy and equitable. That can hardly happen with clear unimposing entry points. There are few in number to keep the processes simple. How could it happen? Simple entry points for child/ youth/ adult and aged care services within regions would make sense. You need sophisticated triage and assessment services that should be available across these regions comprising especially trained psychiatric, psychological mental health immersive and other Allied Health staff. You receive the moderate severe referrals, conduct a timely assessment and then refer to an appropriate service within their area.

Their services would have KPI's around the time taken to first assessment. This would be as I said, sophisticated, comprehensive, lead to coherent clinical management, a plan to proposed interventions based on evidence, and then pathways to care.

Retraining and better access is critical and we agree that mental health plans have evolved little. One problem is that GP's aren't often the best equipped to determine the type or duration of therapy that a consumer needs. Distressed consumers need comprehensive assessment to determine their clinical need. To look at a particularly under-serviced and expensive group, are those with trauma attachment to borderline conditions. They need a comprehensive and sophisticated assessment to drive a treatment plan.

So it wasn't that no one presented with symptoms of depression or anxiety, get a GP mental health plan, see a psychologist who may have little or no experience in the treatment of these complex disorders, deliver then a therapy which is not usually evidence-based, often useless and sometimes dangerous, resulting in more distress for the consumer - most psychologists are trying to be equipped in providing CBT for anxiety depressive disorders but not much else.

Many or most clinical psychologists and some registered psychologists had training in additional evidence-based therapies from more severe anxiety-depressive and personality

disorders. And there are NHMRC guidelines now that clearly describe the evidence in this field.

Certainly qualified therapists need to be identified within networks and they are the people who would receive such referrals from a triage and assessment service. I've got a few other points about the community managed sector. This came up in a recent meeting of the Clinical Advisory Council of New South Wales Health and that generally across the state in public sector services people are finding it difficult in dealing with these – with the range and number of services that are available. Of course, there have been reports of inefficiency and waste with the NDIS rollout and there's consistency among the advisory council that there should be a rationalisation of the community managed organisation sector.

Organisations need a critical mass to support an organisation – organisational structure that can set and train appropriate clinical and corporate government's arrangements and can ensure up skilling and maintenance standards with their staff.

I'll leave it at there at this point in time.

PROF KING: Thank you very much. Okay. I'll start off – and lots of points there. Let me start off though, somebody mentioned at the end which is the difference between psychologists and other therapists in this area and we've heard from various groups, psychologists, counsellors and so on about the issues of what there should be funded (indistinct) potentially via NDIS.

You made a distinction between clinical and other psychologists at least in terms of training. We've also heard from counsellors who are a different group again.

What is your view on which, if any, of those clinicians are relevant at what stage or treatment, clinical treatment for a person with mental health issues. Do we need more transparency over the different training? So for example my understanding is psychologists don't have formal schools of practice. Is that needed? Do counsellors have a role in moderate or severe treatment or treatment of people who are moderate or severe should be able to be different?

Those general views and I'm deliberately asking you as someone who isn't one of those practitioners, but you raised it in your statement.

DR VIRGONA: To answer the last question first, I mean, in terms of counsellors, they can get their qualifications from a range of places, including online as I understand it. I wouldn't have thought that they would have the school-based necessary from such a programs to be able to look after people with moderate to severe psychiatric disorder.

To give you an idea, it's hard to get a sense of what it's like out there and at some years ago in the area that I work in in south-west Sydney, I did a survey of everybody I thought who may be working with people with a borderline or complex, stronger, traumatic stress disorder population. So I sent out a survey identifying more of the psychologists through the APS website who were registered with ATAPS.

I set it out to the community health centres in the public sector. Mental health services and all the counselling services that were run in the area.

Now, I received 38 responses – and that's from about a half a million population and I got 38 responses. They're only about that many people registered for ATAPS in the area. And we found that of that group, these were people who were interested in providing services to people who had borderline and complex strong disorders. They all had some sort of post-graduate extra training in delivery of evidence-based treatments to these people. And they were only seen, I think, as a type, in total about 160 people.

Now, what – in the area. And we thought that there'd be a population of around 5000 people in the area given the expectations at the (indistinct). So this is an incredibly underserved group. And a group that has significant morbidity and mortality and creates a lot of need in the public sector and mental health services, both in the emergency department and the in-patient sector.

So that was an exercise to try to get a picture of what it was like out there and I think what it showed us, is that there are people who were trained and then there are people who are actually – and the idea behind this was to approach the primary health network because they had money for complex and severe psychiatric disorder provision and so I said to them, well, what about this group? I mean, they have complex and severe psychiatric disorder, would you consider funding this to some degree.

And they considered it, they didn't do it ultimately. They considered it and so it was to try and get a little interest in the area around us and whether people would be prepared to come together and be a part with a – they would have to agree to conduct and edit it's face treatment for the disorder, according to the NHMRC guidelines and be part of a peer review process within the group and supervision. And everybody is having to do that.

I think programs like that are possible within a regional commissioning network – regional commissioning authority framework that you can develop networks and conditions, you have identified skills, who are registered within your organisation the same and who can receive referrals for patients in that group.

PROF KING: So a question about access. So any thoughts or comments about afterhours access? We've got a lot of people are saying to us that after hours, it's the sometimes the ED department and not much else. Is there examples of areas where we've done better or we can make some recommendations around proving, especially out of hours access?

DR VIRGONA: Yes, I think there's a lot of scope for innovation around this where the college is working with New South Wales Health at the moment on a workforce strategy, it's like our workforce strategy. I am trying to get New South Wales Health to agree to funding VMO's, psychiatrists work, after hours. The peak period for presentations for people with mental health problems to the emergency departments are between 4 and 11 pm. Yes, that's when our staff have all gone home. Our junior staff, our registrars. And the CMC's you might be working in ED.

I'm hopeful that they're going to pilot this at least and see how we go. So in terms of the public sector, there's no reason why that – why such a model should not work ultimately. We've also tried to get them to look at the staff specialists in order to see if we can marry up our award more with the emergency physicians award - emergency department physicians award. Because really, we are an emergency – we are like emergency physicians nowadays. We've got (indistinct) who are just doing emergency department of work. It is not the ideal place to have people present where you have – that we're stuck with it, we can't see a solution to this in the near future, so we have to adapt to the situation and start to engage in workforce design that meets that demand.

So working in the public sector, yes. In terms of the private sector, there's no reason why Regional Commissioning Authority, could find an extended hours triage and assessment service. You know, running their own mental health telephone access line, linked to treat – and a team who perform comprehensive psychiatric assessment and development and management plans. This is part of the problem really, is that people go for years and years and years, before they get to a point where they're getting a comprehensive assessment so that the actual nature of their problem is identified and so they've often been floundering for years before they get the treatment that they should have gotten in the first place.

If you want to do something with early intervention, then you've got to develop the pointy ends of the business properly with the right people in.

PROF KING: Thank you.

MS ABRAMSON: Could I ask you one question about the Regional Commissioning Authorities? One of the reasons behind it was to use some stability continuity over time, so one of the issues that we'll be interested in when he talked about the triumvirate which was the NGO's that – and the government. How would you ensure that continuity in those circumstances?

DR VIRGONA: Well, I think it's a fantastic question and I think continuity of care is what is really missing from the public sector services at the moment. We used to do it about 20 years ago, I would see my inpatients in the morning and my outpatients in the afternoon at the community health centre. I'll look after them both sides and they stayed with me and it went very well. I think another point on a similar theme is that in – I think there's the lack of a consumer and carer activism in the private sector is because people are getting continuity of care in the private sectors.

So people aren't jumping up and down and screaming about the care they met in the private sector because they get their doctor and they get to see their doctor or their psychologist over a long period of time who knows them and can efficiently deal with the problems that come to hand.

So how would you manage continuity of care? Well, I think within a Regional Commissioning Authority, you would just have a network of clinicians that would be fronted by that authority to deliver services. But delivering packages of care that use - that are determined at the outset. Whatever the treatment plan is at the beginning, somebody gets a package of care. If it's

someone with a personality disorder, they want to get 40 sessions a year with a clinical psychologist who's trained up in that area.

And it may be that at the end of that period of time, it's decided they need an extension to that period of care. They would be allocated a psychiatrist if they were requiring psychotropic medications, who would be the person who would continue to provide the care to that person.

Again, they could be funded as John was mentioning, you could contract people to work for you on a sessional basis in that model or you could pay them a fee and service kind of arrangement. I mean, these are the things that I think, that need to be thought about in a bit more detail and then potentially trialled.

MS ABRAMSON: We'd really welcome your thoughts in a written submission - - -

DR VIRGONA: Yes.

MS ABRAMSON: - - - on some of those things because we really are looking at some of the details of implementation.

DR VIRGONA: Yes.

MS ABRAMSON: Thank you.

PROF KING: Just one last one from me. Again, on the regional commissioning authority funding, you said very strongly that the RCA funding pool should not be linked to the current volume of MBS rebates. You suggest that I think a per head, per unit of population approach, but I wanted to clarify that because the alternative that we see from that the GST distribution in this country is where it's done on the basis of a more means based approach, for want of a better word.

DR VIRGONA: Yes.

PROF KING: So you think per head of population or something else?

DR VIRGONA: I think you'd have to consider particular needs of particular population, so if you've got high need population such as CALD or ATSIC populations that are concentrated in particular areas then there would be a loading that would be applied to those areas, yes, but, you know, generally speaking there'd be a much more equitable distribution of the existing moneys.

PROF KING: One of the things that's done for the GST distribution is of course saying, well, for example, that you're largely a rural and regional state, as some of our states are, then it's more difficult to implement services, it's more expensive, so more money is needed. Is that something that you'd support?

DR VIRGONA: Yes.

PROF KING: Thank you.

DR VIRGONA: Thanks.

PROF KING: Let's take a break for morning tea until five to 11.

SHORT ADJOURNMENT

RESUMED

PROF KING: Perhaps if we can start again. So is it Marie?

MS BUTLER-COLE: Yes, hello.

PROF KING: Marie, would you be able to state your full name, any organisation you represent, if you're representing an organisation, and any opening comments that you'd like to make.

MS BUTLER-COLE: Yes. So my name is Marie Butler-Cole and I'm here today because I'm a carer for a mental health patient with severe and complex mental health issues who has been most recently cared for in the public health sector.

PROF KING: And any opening comments you'd like to make on your experience or - - -

MS BUTLER-COLE: No, it's okay.

PROF KING: That's okay. I think in your notes that you sent through for us you mentioned human rights abuses in the mental health system.

MS BUTLER-COLE: Yes.

PROF KING: Would you be able to expand a bit on what you mean by that and where you've seen examples. We're very keen - it's incredibly valuable to us to have your experience, to understand the (indistinct words).

MS BUTLER-COLE: Okay. I have been caring for my friend over the last couple of months who went in as an involuntary patient into a major public hospital here in Sydney. I feel that their care has been substandard for the duration of that stay. I do understand from reading the report that there is a need to reorient care to the patient, but the report does not mention that there is a need to respect the patient, to not be prejudicial towards their care because of their background, and I feel that there's been a great lack of empathy and consideration towards them over that period of time. Now, over the course of the six weeks that my friend was in treatment, I noticed that there was repeated failure to enable my friend to give informed consent for (indistinct) of medication, proposed tests to be conducted, speaking to external parties in order to gather information about their background.

Their treating team was also regularly telling my friend not to speak to me and constantly asking them if I'm a trustworthy person. Staff were speaking to my friend with disrespect. On one occasion telling my friend that they were whining when they were asking for supervised or unsupervised leave. There was an apology issued over this, however I believe the damage was done on that occasion. In addition to that there was an initial refusal to provide a carer nomination form and there was resistance from the treating team to speak to me, despite myself eventually being provided with that carer nomination form and myself being put onto that form with the consent of my friend.

The social worker at the hospital consistently refused to perform their duties that was expected of them, for example, my friend wants to apply for Newstart Allowance and on two occasions they had the form printed out for them and they were left alone with the form, with the full knowledge that they would not be able to complete the form by themselves. That's just one example of the many failings of the social worker, and it provided a great deal of frustration for me because I had to take over the duties that the social worker should have done and that came at financial cost to me as well because I was on contract with an organisation and I got paid by the hour. I do not get paid for the hours that I was not at work. So in that case financial pressure on me as well, however I realise that the needs of my friend were greater than being at work because without those things being done and such as speaking to banks or to other lending providers or filling out forms for - to be able to speak to the general practitioner, things like that.

I needed to have a (indistinct) when my friend was discharged and I understood those things were (indistinct) by the social workers (indistinct) not doing those things. A registrar told the Mental Health Review Tribunal that the treating team did not want me to be part of the hearing, and that they were of the view that I am over involved in my friend's affairs and that my friend does not agree with me, that I'm not an appropriate person to associate with, that I'm complicating their care and that I'm going to be removed from the list of their nominated carers, which did eventually happen but it didn't really make much of a difference (indistinct words).

Because of these things, I informed the treating team that I applied for guardianship for my friend through (indistinct) and around 9.30 in the morning, because I submitted the forms the evening before, they woke my friend in their bed to tell them that they were going to oppose the application and that if I'm their guardian that apparently I can do whatever I like with them, which is not true.

Which is really, really hard for - not just towards me but that is so hurtful towards somebody who's vulnerable and has limited access to friends and family because they're not from Australia. And then the final Mental Health Review Tribunal, that was conducted shortly before my friend's release into police custody, was a disgrace. It started late and I understand that was due to technical difficulties and, you know, that's okay things do happen, however there were two versions of the paperwork and there were differences that the tribunal members nor the registrar were aware of until I pointed them out, and then it was closed hurriedly as they were running behind. This is somebody's life that they're playing with, and I (indistinct) find that any of these things that make this acceptable at all.

It falls far short of the professional behaviour that is expected for mental health professionals. There don't seem to be any (indistinct) or remedies to modifying this behaviour that my friend

has experienced to ensure that this will not happen to them nor to anybody else ever again. I will say that if mental health professionals behaved in the ways that I've outlined above, that they've got no place in this industry and that they should find something else to do with their lives if they don't display empathy and compassion.

PROF KING: Thank you. Can I ask what would be the effective approach, would be formal legal protections for mental health patients? Would it be some sort of statement of a mental health patient consumer rights. Have you got any thoughts about exactly - I understand your experience, how do we now move forward? How do we make sure that other people don't have to go through what your friend has gone through?

MS BUTLER-COLE: Well over this time period, I've noticed that mental health patients have significantly fewer rights in respect of civil law, criminal law and family law. I'll just find the section where I've written about that.

PROF KING: Please.

MS ABRAMSON: Ms Butler-Cole, perhaps if I can assist you, we do have a part of our report where we were quite aware of the fact that people with mental illness had more disputes, you know, landlord-type disputes, fines, those type of issues. So we were aware of that and then the question for us was Legal Aid, if it funds, generally funds the criminal cases, so the question was what support could be given to those people? So is that the type of issue that you're referring to or something different?

MS BUTLER-COLE: No, I'm referring to the fundamental rights that mental health patients have under current legislation. So for example in the areas of civil law, it is extremely difficult for mental health patients to sue medical practitioners for medical negligence due to the requirements that I believe there's three mental health practitioners that - I can't remember exactly what it was - that need to be in agreement that the treatments which the patient received was incorrect, and I believe that requirement does need to be removed because in this country mental health practitioners are reluctant to speak out against one another for fear of retribution.

MS ABRAMSON: Firstly, can I thank you for - I understand you've made a submission to us as well, another written submission, so thank you for that and thank you for coming to talk to us today. Can I follow up on what my colleague was asking you about the rights of people under the Mental Health Act, I should add that the Mental Health Acts are a bit different around Australia, so if we can have a look at the NSW Act, which I'm sure is what you're referring to. We've given quite a bit of thought to advocacy support for people performing across tribunals, because there's good evidence that if they have access to representation, the likelihood of compulsory treatment is actually much lower.

In the circumstances that you've described to us, where you were told that even though you had the guardianship, or you had the ability to assist your friend, that was not going to be respected. Do you think if you had access to an independent advocate, that would have assisted you?

MS BUTLER-COLE: I'm not sure. I'm not sure. I've had to do all of this on my own with the assistance of some advice from somebody who knows Sydney and more about the supports and services that we currently do have in place. If perhaps the advocate had legal (indistinct)

to be listened to, then that would've have been immensely helpful. But as I was not - as I'm not a guardian for my friend as of yet, I have found that my ability to assist has been greatly constrained.

MS ABRAMSON: And can I ask you, what type of information were you told as to why your guardianship would not be respected?

MS BUTLER-COLE: Well, for the length of time that I've known my friend, like, I mean, how long is a piece of string. Like, there's no limits on compassion.

MS ABRAMSON: Because we are, as I said, we will have bit more of a look at this issue, because the rights - we were talking to one of the (indistinct) before. It's really difficult balancing carer rights, guardianship rights, and the consumer themselves. So in your case, was your friend well enough to say that I want Marie to be my guardian, or my person to speak for me?

MS BUTLER-COLE: Yes, so (indistinct) sent to their treating team and (indistinct) on a number of occasions, and the (indistinct).

MS ABRAMSON: I will have a very good look at your written submission and we may follow that up too. Thank you.

PROF KING: Thank you so very much for coming in.

MS BUTLER-COLE: Great. Thanks very much.

PROF KING: Next we have Nick Kirwan and Cathy Duloy. If you are able to state your names for the transcript, and the organisations you represent, if any, and then any opening comments you'd like to make.

MS DULOY: I'm Cathy Duloy from MetLife (indistinct).

MR KIRWAN: And I'm Nick Kirwan from the Financial Services Council that represents the life insurance industry. So, I wanted to give some background and context to put on the record the nature of the interest that the life insurance industry has in mental health conditions. And recently, in partnership with KPMG, the Financial Services Council has been capturing some very detailed and up-to-date information about the causes of life insurance claims. It does tell, I think, a very interesting story.

And because of the prevalence of the group life insurance in super, we would expect this data to be representative of the Australian population, as a whole. And it's worth saying that last year, 2018, life insurance companies paid out in mental health claims \$707m, just for mental health claims for income protection (indistinct) policies. And mental illness is the second most common cause of claim overall for life insurance policies. It's the most common actually, for total permanent disability, TPD, and it's the third most common cause for income protection claims.

And we have seen - we're seeing that the incidence of mental health claims has been remaining

relatively stable. It hasn't been significantly increasing. But the duration of those income protection claims has been rather increasing, and I should say that because of that, we'll be doing a bit more analysis. We're expecting more data to come in by the end of this month, actually, which will be analysed over the Christmas period into the New Year. So we'd expect (indistinct) have significantly more and better data to be able to report to the community.

But what we can say, at the next level down, is if we look at just mental health claims, the top 10 causes of those mental health claims were 15.9 per cent depressive episodes, 12.6 per cent reaction to severe distress and adjustment disorders, 11.7 per cent anxiety disorders, 7.3 per cent recurrent depressive disorders, 3.3 per cent bipolar, 2.7 schizophrenia, 2.6 per cent is other dementia; that is, other than Alzheimer's, 2.5 per cent Alzheimer's, 1.6 per cent disorders due to brain injury, brain damage, and .8 per cent mental disorders related to alcohol abuse.

So it's interesting we starting to capture that information. That was for 2018. So that was really by way of background. I did have a couple of proposals for the Commission, if I may.

PROF KING: Yes.

MR KIRWAN: Firstly, we note the proposal that life insurers should be allowed the discretion to pay for mental health services in any report, and may I just say, that's an extremely welcome recommendation. But we would like to see that slightly modified in a small way, and that is that it shouldn't be restricted to just mental health. And the reason is that claims for life insurance policies (indistinct) are very complex and can be multifactorial, and what can start off as an injury an illness can lead to mental health the other way - the other area as well. So it's not just one fit, and so by bringing (indistinct) in that way to mental health, we feel that would be perhaps more restrictive than we would like. So we believe it could more helpful than that.

The other recommendations; we heard the recommendation of standard 21, which is that all staff, and not just customer basic staff as at present, should receive mental health awareness training. And again, that's a very welcome suggestion. We are currently reviewing our standard 21, so it's also a very timely recommendation. However, we think maybe all staff might be going a bit too far. There are some back office staff who never come into contact with customers.

But perhaps if we could suggest extending it such that people who are involved in designing the processes that customers will use, people who are designing policies that customers will have, would benefit from mental health training as well. So when they're designing those processes and products, they would have a mind to the sort of experiences that the customers might have.

So those were the main thoughts and suggestions we wanted to put to the Commission, and as a very last point, we have recently concluded a research paper which KPMG prepared for us. It's actually a literature review looking at the importance of psychosocial factors in mental health. And again, we'd very much like to make that available to the Commission. We have a link. And I guess that's (indistinct).

MS DULOY: Yes. I might comment on a couple of things, if that's all right.

PROF KING: Yes.

MS DULOY: So firstly, again, we really welcome draft recommendation 24.6, which we also supported in our submission, and it's something that we've been hoping that we can - that we're really hoping the government will join us on this, because a one of the largest supporters of people with mental health in the country, we think it's really crazy that it would be a criminal offence for us to find someone psychological counselling if they really need that. So we'd really like to see that change.

Just a really small point, you say that (indistinct) work on the pre-conditions.

MS ABRAMSON: Yes.

MS DULOY: To set that up and add preservation of the regulator for insurance, and also private insurance. So we wondered whether they should be (indistinct) as well, or instead. But that, you know, we obviously work with whoever the relevant regulator is. On a (indistinct) we agree that that needs to be done.

So you also asked in your report about what barriers there are now to providing employer funded income protection and this is a product which we offer now where employers can purchase a group salary continuance policy to cover their employees and, in fact, MetLife is the largest provider of such products.

But they are quite tax efficient the way they're offered because they're not subject to fringe benefits tax so, that is quite an efficient way of providing it. The only thing is that claims experienced in those sort of products has been worsening and there's been a lot of pressure on costs and APRA has actually been sort of saying to the industry, 'You need to make these products more sustainable,' because some of them are (indistinct words).

So that's probably the main barrier and, in fact, we've had some employers come to us and say, 'How can we make this cheaper? Could we impose more restrictions on providing the (indistinct) health benefits?' and one that actually came up fairly recently, an employer asked us they've got a 10 year benefit period; could they just have the two year benefit period for mental health. So it does seem to be an area where people look at if they want to try and reduce costs within a policy. So we could provide you with more information on that if that would be helpful to the Commission.

The other thing I wanted to mention is that we also talked in the report about the state of data in Australia and the fact that the ABS survey is now sort of old and it's still the key source of data and you've made recommendations that that be updated and (indistinct words) and we would agree with that. As the next step the ABS's been involved in a big data project to try and get better transparency by course of (indistinct) generally, not just for mental health, and we've been involved in that and we'll continue to support that.

And another area that we think is important is better access scheme has provided huge benefits, but there doesn't seem to be a lot of follow-up in terms of, well, what are the evidence based treatment that people are getting and are they being effective? And, again, if we were to be

involved in providing some of the funding for that we would like to see a bit more process and a bit more governance around that as well. So they're probably our main (indistinct). Thank you.

PROF WHITEFORD: Yes, thank you.

MS ABRAMSON: Could I just ask - thank you for appearing today - I just want to clarify one thing. The reason we'd specified that ASIC is because of the conduct regulator and we saw their role in codes but I'm well aware that ASIC of course would have to talk to APRA because it was mainly because we were thinking about conduct.

MS DULOY: Yes.

MS ABRAMSON: Could I ask you some questions about underwriting? So in determining insurance premiums, how do you assess the risk of mental illness of an individual and how do you take into account the nuances of different types of mental illness?

MR KIRWAN: So in our consultation version of the (indistinct) into the life code, we did speak to a number of people in the mental health community, Mental Health Australia for example, and they were very keen for us to improve the sort of factors that life insurance should take into account and that version of the code does say that we would take into account a history of the condition and the severity of the condition which we believe is in line with what people are (indistinct) are using now when they make individual assessments for (indistinct).

MS ABRAMSON: Can I ask, and I'll be a bit direct so I hope that's okay.

MR KIRWAN: No, please, do.

MS ABRAMSON: But how far into someone's past when an insurer - because we've had a lot of people call us - can an insurer actually look? We've heard anecdotally evidence of insurers trawling through someone's medical history on the general consent form to actually find any inserts where, 'Oh, well, you had depression after you had your baby, we'll deny you mental health cover.' So that's the type of thing that we're quite interested in the standards of the industry and how we could get, you know, to actually get those across the board.

MR KIRWAN: So that, as I understand it, and I think that accusation normally comes with time of your claim rather than when you're assessing an application for cover. But the answer is there's no real hard and fast rule as I understand it about the length of time because it does depend on the condition and some things are relevant and potentially forever; you know, sort of 'have you ever had cancer' is a very material thing no matter how long you go back and it's actually (indistinct) in the past. 'Have you ever had a headache?' Well, of course, we shouldn't go too far back on those kind of things.

So I think it does depend on the nature of the condition itself as to whether it is relevant or not. Some things are relevant for a very long time and potentially forever, other things clearly not so. You know, some things are only relevant if they're very recent.

MS ABRAMSON: I think that gets to the heart of it because it's really about making sure that the - and understanding the role of underwriting because it's a business.

MR KIRWAN: Yes.

MS ABRAMSON: But it's got to be matched with the objective facts about the condition and the person's experience of that condition. So that's really what we were getting at.

MR KIRWAN: Yes.

MS ABRAMSON: And you're right; we have heard, especially with the Royal Commission, a number of concerns about insurers rejecting claims at the time the claim is made, but the claim is just as valid for the underwriting point.

MR KIRWAN: We understand; and the industry through its code is taking enormous steps forward and we want to continue to make those steps to improve the customer experience and it's really (indistinct).

MS DULOY: Sorry, can I just jump in there? We've also recently, with the ABC, introduced the new standard on the consent form which was partly in response to concerns raised by the mental health community and other health groups which is making the consent form a lot clearer and a lot more specific.

MR KIRWAN: Yes, good point. That's (indistinct) come into effect very recently and it's a process with the RACGP, the Royal Australia College of General Practitioners and we're very pleased to have reached an agreement about that so that people are very clear about exactly what they consented to and what they're not consented to and we understand the sensitivity around consultation notes of a GP and the privacy that they have between the patient and doctor and that's why that's treated as a separate category under this new consent form, so people are very clear about very limited circumstances in when those consultation notes could be released.

MS ABRAMSON: That's a very welcomed development because one of the other things that's been raised with us is that people are delaying treatment for the fear of will it deny my insurance cover. So those type of developments are pretty important and we'd certainly welcome a written submission which outlines the notes.

Can I ask you one additional question? Is which goes to this; which is about the stigma.

MR KIRWAN: Sorry? About?

MS ABRAMSON: About stigma.

MR KIRWAN: Stigma.

MS ABRAMSON: So people are not, perhaps, seeking an insurance product because they're worried about disclosure because they're worried about what we've just talked about. But also because they don't want to be 'labelled' with some condition, and I'm just wondering what the industry's view about what we can do to reduce the stigma around having a mental illness.

MR KIRWAN: Yes, of course. I mean it's a community issue I think we're seeing and it manifests itself some clear way. So for example this data that we've recently gained access to shows that when it comes to maPROF KING claims for mental health conditions the delay in notification of those claims is more than six months longer than the average of every other claim.

So people are not coming forward to make a claim on their policy. Perhaps, it's stigma; perhaps, it's other reasons. We don't fully understanding the problems and so I don't think I've got any particular recommendations for the Commission on that, other than to note that it is obviously a community concern and it does manifest itself in ways that we can now see and measure and, you know, we would like to play our part as (indistinct) in doing what we can to address it.

MS ABRAMSON: Well, we'd be really keen on seeing that data that it's a six month period.

MR KIRWAN: We can make that data available to the Commission, we can certainly give - it applies in both income protection and total disability claims where people take longer to submit that and, of course, that's a shame that people are not working but, of course, the sooner they submit the claim, the sooner they can get that much needed financial support.

MS ABRAMSON: And, you know, you would've seen, we have a really strong need for some early intervention and the treatment they (indistinct) particularly (indistinct).

MR KIRWAN: And of course late notification is a barrier to that early intervention because if the life insurer doesn't know that the person has got, you know, a mental health condition for, you know, an average of an extra - it's not six months, it's and 'extra six months' - then, of course, it's very difficult to see how, you know, the early intervention could apply.

MS ABRAMSON: I'll also ask - - -

MS DULOY: Also, again - - -

MS ABRAMSON: I'm sorry.

MS DULOY: The recommendation in relation to delaying interest to finding health services could also help with early intervention as well, because (indistinct) say for TBB they're on a six month waiting period, if we could maybe provide the person with some support during that period. That might be helpful from an early intervention aspect as well (indistinct) important to be booked into (indistinct words).

MS ABRAMSON: No, absolutely. Can I also ask; I understand, and you'll correct me if I've got this wrong, that an insurer cannot deny cover to a person once they've made claim. There's something in the insurance contracts that (indistinct) so you make a disclosure; you make a claim. As I understand it, you can't not underwrite them for the (indistinct).

MR KIRWAN: You're exactly right.

MS ABRAMSON: Yes.

MR KIRWAN: The assessment of the person (indistinct) medical background and history and other things only take place when people apply for cover. Once you've got the policy, you're not required to make any further disclosures if your health changes for the worst in some way. You absolutely keep the cover you've got for as long as you want to.

We do have something if the (indistinct) situations occur we (indistinct) just to make clear to people that if their health improves in some way then, there's absolutely no reason why people can't come to their (indistinct) and say, 'Look, I had this condition in the past which is (indistinct) affecting me; it's been five years. Please, can you think about removing that (indistinct) or that extra premium or whatever.' But, of course, that's something the customer can choose to do if they want to, but there's absolutely no requirement or coming forward and saying, 'Look, my health has got worse in some way,' you just don't have to disclose anything other than (indistinct).

MS ABRAMSON: Can I ask one final question? My fellow commissioners are being very indulgent of me. But what about the premiums? So you make a claim on the policy and then you underwrite for (indistinct).

MR KIRWAN: Yes.

MS ABRAMSON: So does that mean that because you've made one claim your premium rate will change?

MR KIRWAN: No, no.

MS DULOY: No.

MR KIRWAN: That's actually against the law.

MS DULOY: Yes.

MR KIRWAN: So if life insurers want to raise premiums, they have to raise premiums so everybody will (indistinct). You can't pick on, you know, Ms (indistinct) has made a claim, therefore, we're going to put her premium up. That's what'll happen.

MS ABRAMSON: Thank you so much.

MS DULOY: We can only raise the rates across the board for getting the (indistinct) that's in the life insurance (indistinct).

MR KIRWAN: For the (indistinct).

MS ABRAMSON: Thank you.

MR KIRWAN: Thank you.

PROF WHITEFORD: So one question from me. So you mentioned that the frequency of the number of claims for mental health hasn't changed, but the duration of the claims has.

MR KIRWAN: We'll know more about that in the first quarter of next year and that's the early indication we're seeing.

PROF WHITEFORD: So I guess my question would be if the person is getting early treatment and effective treatment and the right treatment then, you would hope that the duration of claims would be reduced as much as possible and I noticed that some of the conditions in your list - in fact, the second is - I'm sure you know the diagnostic criteria around these - but adjustment disorders by definition don't last more than six months after the stressor that triggered it is gone. So either the stressor is still there or that disorder, by definition, has to remit.

So I guess from a clinical point of view we'd be concerned to ensure that the individuals are getting the right treatment and whether they're being treated by a clinician who, perhaps, isn't providing the optimal treatment that that individual needs. It might come to the issue about, you know, being involved in the treatment more, but do you have any data on who is being able to provide the treatment for the people who are insured?

MR KIRWAN: We don't have data on that. We do have some concerns. So around 80 per cent of the data we get is assessed using the ICD-10 codes for international classification of diseases (indistinct) to assess this - and I think we feel very confident that if someone goes through a psychiatrist and they're diagnosed, I think we would expect them to fall into exactly the right category of that particular - there's about 120 more of those categories - whereas we, perhaps, don't have quite the same level of confidence if someone is being diagnosed by a general practitioner. We don't have any hard evidence to support that but there is a question about, you know, given this long list of classifications, whether people are always in the right box and therefore the extent to which we could rely on that level of detail of the data. But that is a question in our mind, I'm certainly not making any accusations, you know, at this point, but there is a question about that.

MS DULOY: Yes, we don't have any sort of data on that too, but anecdotally we have had claimants who are claiming for a mental health condition but they're not actually receiving any treatment at the time of the claim because they've already tapped out their benefits.

MR KIRWAN: Still obtaining the psychiatric treatment.

MS DULOY: Yes, (indistinct) or if they're getting any treatment, it might be the odd visit to the GP. But it's not - there isn't a formalised treatment plan for their condition.

PROF WHITEFORD: So I guess my comment in response to that would be that the 10 sessions is the annual cap under better access for allied health provisions doesn't apply to psychiatrists, GPs and certainly in the public sector. We've been alerted to the concern around the 10 cap limit and have recommendation in the draft report about that. But clearly for someone who is needing to continue to claim, one of the things that we would want to hope that optimal treatment had been provided and that if they remained incapacitated by their illness then, that everything that can be done has been done to address that. Thank you very much.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you.

PROF KING: Next, we have Irene Gallagher. Just state your name and organisation for the transcript and then, any comments you'd like to make.

MS GALLAGHER: Thank you. So my name's Irene Gallagher. I'm a CEO of Being, the New South Wales peak organisation representing people with mental health issues. Thank you, I do have an opening. So thank you to the Commissioners, the Productivity Commission, for the opportunity to present the views and perspectives of people in New South Wales who are living with mental health issues and emotional distress in today's hearing.

As I mentioned beforehand, for some background, Being is the New South Wales peak body speaking with and for people living with mental health issues. I'd like to take this opportunity to acknowledge the members of Being that we serve and represent and thank them for sharing their experiences and perspectives which contribute to our submissions and points for today.

We would like to thank the Productivity Commission for their draft report and for highlighting key recommendations which are pertinent to our community. Our members have raised a number of key items for consideration by the Commission outlined in our submissions for today, and whilst the eight points that we have noted are in no way exhaustive of what our final report will conclude, they are key items to our members and to our community.

So many have expressed to us that they feel the final report needs to acknowledge the real experiences of real people who are often stuck in broken systems or who fall through the gaps of service provision with nowhere to go. Key to the final report is the recognition of the current system entrenched with a biomedical lens with biomedical language which treats people as illnesses, first and foremost.

People don't heal in places that focus on biomedical lenses, focused on illness rather than recognition of their distress from childhood, environmental, relationships, broader community, stigma and discrimination in our society. They heal in spaces in which truly nurture and recognise people's trauma histories in ways in which we heal.

As a starting point and at the heart of the work, and hopefully the discussions that we will have ongoing for this final report, we would like the Commission to consider a fundamental factor in approaching the development of the final report. If we are to truly change the way systems and services operate we need to shift our thinking from the current dominant biomedical discourse of pathologizing individuals as though something is wrong with them; lacking, inadequate, gauged.

Our approach should always be one which questions what has happened to you, not, 'What is wrong with you?' (Indistinct) alliance with the basic human rights, social justice principles and acknowledges social determinants such as housing, finance, work, connection, isolation, poverty, racism, sexism. I would now like to discuss some of the eight points that we have noted. Thank you.

PROF KING: Yes, so just dot some of the points that you've noted. Let me start off with consumer involvement, consumer career design.

MS GALLAGHER: Yes.

PROF KING: So we've discussed some areas and some recommendations with regard to consumer codesign. What would you want to see more in the defining (indistinct)?

MS GALLAGHER: The fundamentals to any systemic change or the broader approach that I believe that the Productivity Commission is looking to take and also what's needed for our community, is to ensure the coproduction, codesign and codelivery is embedded in every aspect of the report. I don't think that we can have it in one section or one recommendation. It needs to be entrenched and underpinned throughout the report.

We know for a fact that there's sporadic mentioning of consumer involvement and engagement in the report. We'd like to emphasise the needs to ensure an overarching sentiment, the coproduction approach to (indistinct) reform system. We'd like to ensure that threaded through every recommendation is codesign and coproduction and (indistinct). We know the coproduction, codesign, co-development redefines a relationship from one of beneficiary or dependency on services to one which shares a mutuality and was positive for all involved and we believe this is a fundamental aspect that needs to be informed through this report.

PROF KING: Thank you. One other thing I'd like to touch on; you've commented on peer run services and I guess my slight confusion there is we see, and I think we understand and we (indistinct) many difficult hearings who have reemphasised - it's the importance of peer involvement and peer support staff, for someone who has been (indistinct) mental health, just being able to sit down and talk to someone who's been there and the important benefits that can create.

I get the impression that you feel that's not enough; that there needs to be something more, but I'm not quite sure that I understand what that more is. So do you mind explaining that?

MS GALLAGHER: Sure. So we don't want to devalue peer support that's on offer now, and many consumer workers that work within systems and services. We're talking beyond that. We're looking at opportunities for services that are specifically run by peers. There's enough evidence that supports the efficacy of peer support and to have peer run services and there are already some throughout Australia which have peer run services where people can be with like-minded people in an environment that's a nonbiomedical model. I think that's the key - it's a nonbiomedical model, and I know that there are some endeavours to establish almost like safe spaces in cafes. So we have the first safe haven café in St Vincent's in Victoria.

But an appreciation is that it's still based on a biomedical model; it's still attached to mental health services. How would it be if we had opportunities for people to come and visit through drop-in centres or safe spaces that people could be as an alternative to emergency departments for example, to just be with their peers to be able to sit and to talk and to share stories of hope.

It's a fundamental aspect that I think is not necessarily acknowledged and doesn't have whole strength in the current draft report. The fact that through sharing of our stories through hope, the recovery is possible, that we can heal from our traumas, to be with likeminded people. I don't think we can underestimate that.

PROF KING: Can I just follow up on that before passing it over to my fellow commissioners because the approach that we've taken, and I understand that you have some concerns about the sort of architectural approach bringing (indistinct) for psychosocial supports more broadly, is that we set up the institutions, the framework, the governance structure, but then it would be up to the relevant commissioning authorities, it could be a regional commissioning authority, with those with lived experience as part of that commissioning authority to determine what are the right services for their specific area and we've been quite deliberate. Well, we haven't said, 'They should be peer-run services,' or they should be some other form of service, and that's quite a deliberate approach that we've taken because, of course, it depends on the region. I mean that's the whole point of going and adding it on a regional approach is simply to allow that flexibility.

Now, I understand though that you've got some concerns with that and I'm worried if - - -

MS GALLAGHER: Yes.

PROF KING: Could you expand on that? Because I'd really like to better understand exactly what those concerns are and whether they're deep issues that we need to grapple with or it's partly that we haven't explained ourselves.

MS GALLAGHER: I think there's a couple of different stages there and (indistinct) if I can start off by considering the words of Professor Mike Slade who's from the National Health Service in the UK and he's been instrumental with developing recovery-oriented services, processes supporting the development of the peer work force.

Mike Slade's words, he talks about us being disruptive innovators and I think sometimes we need to think outside the box rather than thinking of the same-old, same-old and seeing how we contract administrator broaden what we already have and I think we have to be really careful that we don't get into that mindset that we actually look for alternatives, and that was part of the reason peer-run services and key-run organisations.

As far as the architecture of the report about some of our concerns were particularly in regards to national commissioning and where does that leave people at a local level, where does that leave the current peer organisations. We know that there's diversity amongst allied communities, we know that there's diversity for people in rural and remote areas, for older adults, for youth. We know that there's diversity amongst the LGBTI communities, with core communities in the forensic system. It almost seems like there's a one-size fits all approach and that's the feedback that we have received from our members.

PROF KING: Yes.

MS GALLAGHER: So how can we look a little but more diversely and consider opportunities that are a little bit more diverse rather than thinking, 'Okay, well, we'll just, for

convenience or for ease potentially, we'll sort of stick things in a national box and hope for the best almost.' I think we're not really observing fundamental needs of people, their diversities, but also at state levels.

MS ABRAMSON: Thank you, for appearing today. Thank you for taking the trouble to be quite clear about the issues that you want to raise. We really welcome a submission and especially around when we talked about national commissioning because we did see that as a role for some areas like suicide prevention when you're trying to roll out a program across Australia, we're very open so, we welcome your thoughts on that.

MS GALLAGHER: Can I just mention through the hearing? I think we also have to be careful because we're starting to see some sort of a separation between mental health and suicide prevention. So, whilst I appreciate that approach, we must also acknowledge that many people with mental health issues take their lives.

MS ABRAMSON: Yes.

MS GALLAGHER: And so whilst we have diversity through say for example mental health suicide prevention, and commissioning happens in different ways, we're already seeing that in mental health and in the mental health sector, but also drug and alcohol. But there is necessary collaborative working relationships that need to happen. So I would just point that out to the Commission as well.

MS ABRAMSON: Understand; thank you.

PROF KING: Thank you very much.

MS GALLAGHER: Thank you.

PROF KING: Next, I think we have Jac Van Velsen who I hope I have not done terrible things with your name.

MS VAN VELSEN: It's Jac.

PROF KING: Jac; okay. It was my very poor attempt to think it's a Dutch last name with a Dutch pronunciation for the first name. My apologies.

MS VAN VELSEN: That's okay.

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

MS VAN VELSEN: Yes, lovely, thank you. So my name is Jacqueline Van Velsen and I'm CEO of WISA Wellbeing in Schools, Australia. I'd love to just thank the Commission with the opportunity and also, acknowledge our traditional owners of the lands on which we are meeting. I would also like to congratulate the Commission on the great work of the draft that they've already produced.

I'd also like to start by just acknowledging education is probably one of the most important social determinants of health, as Professor Michael Marmot has indicated, and has seen first hand in the last two decades I've been working in school communities, that the life trajectory of young people in terms of their health is influenced in a major way by how long they stay in education. I know that you've acknowledged that in the report. However, our real emphasis is in supporting the most marginalised students in Australia and ensuring that the longer they can stay in education, we know we're actually changing lives and their mental health and well-being.

So our organisation, Wellbeing in Schools, Australia, is the only national provider at the moment training and support for school staff targeted specifically to enable them to effectively undertake the wellbeing role in schools. So we build the capacity and capability of school staff to address a whole school community approach to wellbeing, acknowledging that includes all aspects of health and that mental health is not separate from the other aspects of health.

We're a national not for profit; we do this with no government funding, despite numerous and ongoing requests to state and federal governments, because primary prevention and early intervention in this space has not been an area where they have invested a great deal of money.

We build the essential skills and knowledge that those school leaders of wellbeing require and we provide them with highly effective tools and resources, combining (indistinct) best practice from Australia's leading academics and practitioners with the tools to identify and address their own school's specific needs.

We've currently got a 98 per cent satisfaction rating from school staff which is of course feedback data regarding both our training and resources meeting their needs and so we have about 4000 people, as I said, that we provide this training to. So it's given us, as we've been doing this work, we've also been collecting evidence. We work closely with the school communities and education and health jurisdictions across Australia and we've done so for a lot of people for the last two decades.

I'd like to just start by challenging the draft report's concern that it is too difficult in navigating state and federal partnerships across health and education. It's something that we did very successfully with KidsMatter and (indistinct), the first national mental health and wellbeing initiatives for primary and secondary schools, something that we've rolled out across the country over the last two decades.

So we bring over 20 years of experience and expertise in implementing mental health and wellbeing into primary and secondary schools across Australia. We work closely with drug education staff who, previous to this time, had been on the ground for a decade in the 90s doing early prevention work, and they very generously shared all of the effective implementation science. So we've been developing this and can now bring over three decades of that implementation science to ensure that effective implementation into schools is part of a school's core business, not an added extra.

During our Kids Matter (indistinct) we identified a huge gap which led us to the establishment of our national not for profit organisation and that was that more and more initiatives were

being thrown at schools in this space of mental health and wellbeing, but nobody was actually working at building the capacity for people in school, predominantly teachers, to do this work.

So we decided to currently - well, we built and provided a wellbeing training and support directly with those school leaders of wellbeing, to school leadership, to school staff, to students and to parents. As I said, over the past five years we've worked with over 4000 school staff and then additional others in terms of the parents and the students.

We've also been collecting data from them on the strengths and challenges that they face in addressing mental health wellbeing and sadly, we have actually seen a number who, with no training experience, we've seen the impact accumulative of a carer's trauma and resulting in their burnout and their own mental health disintegrating.

Whilst mental health is certainly the most common issue; so this is some of the data that we've been collecting over this period. While mental health is the most common issue they address, it is not the most challenging which it was when we first started this work two decades ago. So there's been a huge shift in what's happened in schools.

Currently family custody, homelessness, school refusal, truancy are the most challenging issues. So I would agree with our previous speaker; in terms of it is an issue of facing those social determinants of health and not just looking at the mental health on its own, and sadly, some of our most marginalised students have been also quietly being exited from the education system, which really concerns us, this data that we're seeing across the country. If they're too challenging or there's too many issues, sometimes school, with a lack of empathy and understanding, quietly exit them out of the system.

We're particularly concerned by other data that we've identified. So for example the majority of the people in these wellbeing roles in the schools have been in them for two years or less, so there's quite a high turnover. The majority have no formal training to undertake the wellbeing role; they're predominantly teachers; just under half are saying that the wellbeing role is not manageable and the wellbeing needs of the students are increasing and becoming more complex, and we're seeing that right across the country; staff are not often fully aware of their legal obligations or have the essential skills and so that's the things that all of these we're addressing in our training.

A staggering 98 per cent do not know the most effective interventions to address bullying. So we've been working with our two leading international experts in this space; Professor Donna Cross from the University of Western Australia and Professor Ken Rigby from the University of South Australia, but this is a major human right abuse because Australia is the signatory to the international rights of the child that all children in Australia should be able to be educated in a safe and supportive environment, and we can clearly say, we haven't come across a school yet that this is in place and this is damning because we've got mentally, vulnerable young people and you can do all the social and emotional learning and training you like in the world, but if the places aren't safe, then it's not going to be effective.

A quarter of the staff in the wellbeing role do not have a role description. 85 per cent state that resourcing of wellbeing is inadequate in their school to address these growing needs. We know in Australia that we've got broader data in like 1 in 6 children living in poverty; 1 in 5 - 1 in 4

experience a mental health; 1 in 4 witnessing family violence; 1 in 5 going to bed hungry and school hungry at least one a week; 7 per cent of our students having a disability; 11 per cent are of a diverse sexual orientation; 50 per cent of our students are bullied in the middle years of schooling - direct links to mental health.

Also, which is really concerning, a very recent trend is - and we think this is underpinning a major increase we've been seeing in mental health issues, particularly in the upper primary years - is sleep problems in school-aged children are wide spread, with a direct link to mental health when they're sleep is disturbed regularly, and we had data through (Indistinct) Australia and other sources that show 31 per cent of 6 to 12 years olds are accessing electronic devices between 10 o'clock at night and 6 in the morning, and up to 83 per cent of those by the age of 18.

So what we're seeing, and we know that the work we've been doing with Sleep Health Foundation Australia, is that if that deep sleep, our circadian rhythm, gets disrupted during those night hours on a regular basis, there is a direct link to greater increase in anxiety and mental health issues.

So in finishing up here, together with our bullying findings and the sleep deprivation, we're really concerned about the continued increasing poor mental health, in particular, this trend moving into the upper primary school and increasing numbers. Our most marginalised young people and children are too highly represented in this data. It's not just an emphasis on social and emotional learning but (indistinct) need, it is inclusive welcoming cultures and safety that need to be addressed.

I urge the Commission to consider this data and address the social terms of health. Things like universal breakfast programs, uniform and educational learning resources being available for all students in our schools so they're not keeping silent out of shame and not turning up. We're not just throwing training and support into the online space. The evidence of best practice is blended learning; build a relationship face-to-face in our schools and our most marginalised schools, we need intensive support to build a whole of school approach to addressing mental health and wellbeing.

Yes, there is a plethora of initiatives. Schools grab the latest shiny ball and WISA likes to help them to build sustainable, whole school approach to wellbeing using their needs data, guiding them in what are effective projects and what is the evidence of best practice. We need that balance of mental health and education providers working together with schools and, yes, those federal initiatives that exist at the moment need evaluation. Please, stop throwing millions and millions at them without that having been done.

PROF KING: Thank you. I'll start with one; but possibly comes out of left field a bit. But just listening to your comments on the importance of social determinants and more needing to be done at school, and you mentioned things like breakfast clubs, uniforms; we've obviously heard about things such as the extra activities that schools charge for, and I know it differs between different states. But to what degree should we be thinking about or should this issue be thought about through the funding lens of the school. How much can change in the approach to funding the school? Is that a tool that we should be talking about? We haven't at the moment.

MS VAN VELSEN: Absolutely. The majority of the high needs that we're seeing and the escalation with mental health and we're hearing from schools is lack of resources to do this. Our current school and the focus on their NAPLAN and results, they're at capacity and we're hearing that regularly that they're at capacity.

We know that when we started rolling out the KidsMatter, Mindmatters which is now their new initiative two decades ago, we had people turning up in droves just simply because the training was free and it is a huge impairment. They don't have the resourcing, and I think if we can embed key wellbeing dollars into this space, it would make a dramatic difference, and I was concerned in the report that already, they were looking at, if they were going to appoint a wellbeing person, that it might be shared across schools and I think this really needs to be addressed on a level of need combined with the population because so many areas of need are massive and it may simply be that certain families have moved into a community and suddenly the school is crippled with, you know, extra high-needs and the resourcing and extra support they need to put in; so needs is critical.

PROF KING: Thought on how that would be made, implementable. So let's take the example that you just finished with there.

MS VAN VELSEN: Yes.

PROF KING: So at the moment to the degree that there is different funding on the basis of needs, it's done at quite a high level for schools. So it's done on SES calculations for example by post code; but that doesn't really take account of when there is, as your example, one or two families with high needs move into the relevant school zone. Is it possible to make funding flexible on that basis or do we need to come at it through another lens? Does the funding need to follow the family in that situation? Any thoughts on that?

MS VAN VELSEN: Yes, I think schools, if they are given the tools to identify the level of wellbeing needs of students upon entry and then in the subsequent years because things like bullying can happen overnight and compromise kids' mental health quite dramatically. So it's not just families, it's what's actually going on, and I also mentioned in the - how schools can become quite toxic depending on the leadership of the school, the focus on wellbeing or on, you know, purely a high-achieving academic school and we don't believe in this, you know, welfare (indistinct) you know, add-on nonsense that some people believe in. Those things can have a massive impact into how healthy the school cultures are.

So universal data collection in terms of identifying wellbeing needs across schools would give you that indication of the changing nature of schools, and collecting that data directly from students, collecting that data from the parent community and also from the staff at the school so, you know, you've got cross sources, yes, just more reliable.

MS ABRAMSON: I'm very mindful of time. So could I get you to take some questions on those? I don't know if you were intending to put a submission in, but we would warmly welcome that.

You mentioned a few sort of programs in half-sense. So we're looking for really practical recommendations that could be implementable and I know, you know, when you're talking about circadian rhythm, I know for example in Victoria, I think it's Templestowe, Doncaster, they actually have the kids in senior years starting later in the day. So practical recommendations would be warmly welcomed by us. Thank you.

PROF KING: Thank you very much.

MS VAN VELSEN: Both thank you for the opportunity.

PROF KING: And next, we have Fred Cicchini. If you could state your name, organisation if your representing one, for the transcript, and any opening comments that you'd like to make.

MR CICCHINI: So thank you to the Commission and the Commissioners. My name is Fred Cicchini. I'm the CEO of an organisation called the Better Health Generation. Our primary work is to deliver psychological and other clinical services to those that are unemployed on the Department of Education Employment schemes and those that are participating on the NDIS. We're an Australian owned organisation and we also operate in the UK.

Today, I wanted to speak about the work that we do briefly and bring to the attention of the Commission three key points. In the last 12 months our organisation would have worked with approximately 10,000 individuals on the unemployment schemes. That's both the job searches Australia deed and the Disability Employment Support deed. We would have worked with about 10,000 consumers in that same time that we were NDIS participants and taking services from the NDIS insurance scheme.

With that work, predominantly we employ approximately 200 psychologists. We are a private business and we reinvest in our staff through PhD programs which we're undertaking nine through universities in Queensland and Montreal, and soon to be the UK, specific to mental health and to the interaction between mental health and work.

We support and nurture those most disadvantaged in society. We speak a lot about mental health and psychosocial disadvantage, but they are no more disadvantaged than those that are subsistent on welfare payments with a mental health issue, that may or may not be diagnosed.

Often our clinicians with working with individuals maybe the first health professional that's ever heard a disclosure about mental health symptoms. We do this work because we understand, regardless of presenting issues, the routine of work puts people in a position where they're better when they're working than when they're not.

Being a private provide in a system that supports the most vulnerable, we have seen some structural issues that we wanted to bring to the attention of the Commission, consistent with the draft report and recommendations. Those three points are: workforce log jams are associated with registration practices through the Australian Health Practitioners regulation agency; also the juxtaposition between work, those vulnerable people with mental health issues going into work or returning to work over a period of unemployment and some of the issues that they may face.

The idea that the world of work is an environment where people can support their mental health, but often when there are mental health issues, they get trapped in adversarial systems like insurance and finally, the absence of a coordinated national strategy for those that have recognised their mental health issue, have found recovery and are living restively with mental health conditions but would benefit from a different system of monitoring, perhaps, a light touch, self-directed, potentially technology-based approach to ongoing maintenance of self-support.

Those are the three points I wanted to raise with the Commission and I'm happy to discuss them.

PROF KING: Okay, thank you, Fred, and can I come back to your point on individuals trapped in the vicarial system like insurance. We've made some recommendations in the draft report around that. One of the obvious ones is under the workers compensation claimable there should be immediate treatment - - -

MR CICCHINI: Indeed.

PROF KING: Not immediate income for the treatment to help individuals get back to work, it helps them to recover. Do you think we should go further than that? And if so - because workers compensation insurance is an adversarial system. Do you think we should go further than there and, if so, how?

MR CICCHINI: I believe that work, being a third of an adult's weight in life, may not necessarily be the trigger of a mental health issue but is a very likely venue. In the workers compensation environment you have the needs of the employer, the needs of the participant and an insurer. Whilst the insurer may be encouraged to give treatment with no liability loading to the employer, ultimately the insurers are declining more psychological claims than they're accepting. At one point, I understand, because I used to work in that industry, that up to 80 per cent of psychological claims were rejected based on the idea that it was an industrial relations issue.

Ultimately, with work being the venue, if we could provide people with an alternative to adversarial systems like workers compensation, that being the idea of self-referring through their general practitioner specifically to issues like the medical (indistinct) assessment specific to a work-related item number. The idea that somebody could recognise that work was an issue that may be perhaps a symptom of other concerns they're having and using their GP, unfortunately at the moment typically when you go into a GP with an issue and you rate work as a concern, you're likely to have workers compensation tabled as one of the issues that the GP and the client will discuss.

Our hope would be that other avenues of remedy were put into place. The idea of encouraging a mediation system as opposed to a compensation system with workers' rights. The idea of taking things out of the binary world of industrial relations and workers compensation and recognising that people could be having a difficult time at work and a difficult time elsewhere, perhaps get the support of their GP for treatment in that regard but with a specific goal, which is currently lacking in better health referrals to maintaining economic participation and work.

If we educated GPs about the psychosocial benefits of work and how they could hold people with mental health and give them competency at mastering where other environments of their life may not offer that, we might find that work becomes a safe haven for people as opposed to a battleground where they have to justify how well they are and why it was somebody else's fault.

PROF KING: Can I just follow up on the specific goal to maintain work, so in some ways we discussed issues relating about it in our draft, of course, but one of the things that was very quickly pointed out to us was the small business people saying, well, that's all fine if you've got a large organisation, so if there are issues occurring in a workplace, then people can be moved around, relationships can be changed within the workplace. But small businesses came back to us very quickly and said that's just completely impractical for small businesses. So how would you see that being done when a lot of Australians work in small businesses that may not have the flexibility?

MR CICCHINI: Again typically when the workplace becomes the battleground, we've moved past that point of structured early intervention. We've moved past the idea of speaking to the GP about broader issues and going to the GP about a work-related problem. There are programs historically like Jobs in Jeopardy where to get that support, you have to disclose to your employer and the employer has to support from time to time your application to get additional assistance. Again, if we moved away from the idea of using self-disclosure and potentially stigmatising people to allowing people to realise that they were perhaps placing their employment in jeopardy because of other issues and using links to their GP and a specific employment retention style service through clinical intervention, then we might be avoiding these issues that small business do face.

Ironically, in the work, in workers comp, it wasn't often small businesses that were sticking point, it was larger or moderate businesses where a workers compensation claim had stigmatised the claimant so much that there was animosity between them and their direct manager, particularly when it was related to bullying and harassment. One of the issues that we see is that there's very little mediation done and when insurance companies decline claims, what they fail to recognise is the fact that the individual is still employed there.

So typically we're contributing to turnover in employment and cost shifting into other insurance schemes when someone says they have a mental health issue, that claim is declined, they've got no option but rather than deal with the stigma, to leave the organisation or for somebody else to leave the organisation, many of those people find themselves on the unemployment scheme or potentially on the life insurance scheme.

So again, I think one of the points we make is in the workplace environment, if we were contributing to a better understanding of mental health and the fact that it's not an adversarial system, that there doesn't have to be somebody that is wrong when somebody else is experiencing a symptom, perhaps we could move to a place where that education keeps people supported and retained in the workplace, regardless of what's going on for them.

MS ABRAMSON: I just had a couple of questions and also some of them you might need to respond to in writing, if you wouldn't mind.

MR CICCHINI: Indeed.

MS ABRAMSON: Given your experience, we're very interested in the individual placement and support programs. They seem to have - although they are quite costly, they do seem to have very good outcomes. So interested in your experience with them.

MR CICCHINI: I would agree that the outcomes are certainly there, the cost is always an issue when we're talking to a scheme like that, as is appropriate indemnification. Perhaps the biggest issue that we have is those that join the workforce and support their own economic participation that may or may not be in that chronic zone, if you like, are people that are still vulnerable to perhaps having a change of circumstances and needing a support program like that without having the support of the scheme because they've moved past it.

What we'd look at is the idea of a systemic approach to a self-supporting mechanism where people with an acknowledged mental health issue that want to self-support and maintain the maintenance of their recovery could dial into something, whether it be a Medicare item or a similar service, perhaps using technology, which is like touch, easy access, to maintain their recovery. We often put in a lot of money at the beginning of a service and for those that are chronically unwell, ignoring that those in the middle, there's a really good return on investment by allowing them to maintain their wellbeing, as opposed to waiting for a crisis point when they slip into a system and there are delays in them getting the support they need.

MS ABRAMSON: Thank you. The final thing and I will get you to take this on notice, going in your own time, is we're very interested in employee assistance programs.

MR CICCHINI: Indeed.

MS ABRAMSON: And what you would think would be the key criteria, minimum benchmarks and also of course maximum. But if you're happy to make a submission, we would really welcome that.

MR CICCHINI: Indeed.

MS ABRAMSON: Thank you.

MR CICCHINI: Just one final point, with the Australian Practitioners Regulation Authority, we currently have a number of potential mental health professionals that are waiting for registration. We could currently be deploying up to 18 people that have waited more than three months into regional and New South Wales, places affected by fire, drought and other economic indicators.

I would ask that the commission consider whether or not there is an improvement in that particular area, whether technology and other sources, Medicare, for example, can register a clinician online using driver's licence, passport and as a registered health professional, I can use that system to get registration numbers and create new venues for my service.

When we're looking at people entering in the industry from recognised Australian universities and coming to employers that have already interned one to 200 individuals. The idea that there

would be any delay in deploying people into the market, a market that desperately needs them would be something that I think the productivity commission could look at with an idea of perhaps an improvement.

MS ABRAMSON: Could you perhaps just give us an indication of what types of individuals or qualifications, is it what types of people are - - -

MR CICCHINI: Australian Health Practitioners Regulation Authority registers all allied health and general practitioners. So predominantly in this instance I'd be talking about psychologists. For example, the average occupational therapist that we employ takes about two weeks to receive their registration. The average psychologist is now blowing out past three months. These are accredited degrees from Australian universities. These are individuals that have passed all the requirements, have been given a supervision plan from an organisation that's done hundreds of these in the past and the delays are there and the delays are systemic and industry wide, as we understand it.

MS ABRAMSON: I see, thank you.

MR CICCHINI: Thank you. Thank you very much.

MS ABRAMSON: Thank you.

PROF KING: Thank you very much. Just before I pass over to (indistinct), I have a plane to catch at about a quarter to - well, I (indistinct words) getting on a plane at a quarter to, so my apologies that I won't be here this afternoon.

MS ABRAMSON: Thank you, Stephen. Could I call the Australian Services Union, please. And if you could be kind enough to say who you are and where you're from for the purposes of the transcript.

MS WHITE: Thanks. My name's Linda White, I'm assistant national secretary of the Australian Services Union, which is the largest union for non-government social and community services workers. I have with me a number of people, including four workers from the non-government social and community services sector, who will introduce themselves briefly because it's important - we think it's important that you understand their kind of experience. They're not here representing their organisations and they may not disclose that on transcript but they're here representing us and other workers in their sector. Also I have with me Jan Primrose and Leon Wiegard, who are both from the Australia Services Union. But if I might ask starting maybe down that end, Robert to -

MR HABEL: Yes, Robert Habel. I'm from South Australia, in Adelaide, and I work for a large NGO and I'm a mental health community support worker and I've worked in that industry in the organisation for 19 and a half years. Thank you for the opportunity to talk.

MR FARR: My name's Nicholas. I'm from Victoria. My background's in education but I've been in mental health for the past three years. I've worked in MHCSS, with PHaMs, I've worked in as an NDIS support coordinator for a while and now I (indistinct words) services.

MR COSTELLO: Hello, my name is Cormac Costello, I work for a specialist homelessness service here in Sydney. So I come from a psychology graduate, worked in community mental health in London for many years and more latterly worked in mental health here in Sydney and now in homelessness. So my site is in a sort of outreach, meaning we go and engage with rough sleepers in the city of Sydney area.

MR DOWSETT: My name is Liam Dowsett and I have worked in the sector for eight and a half years, first as a peer worker in the Personal Helpers and Mentors Program and that program was closed down or slowed down due to the roll out of the NDIS. I moved to a state-based program, which is the HASI program, the Housing and Support Accommodation Initiative. So that's where I am now. I've been there for two years.

MS WHITE: So I should also mention that the ASU has significant numbers of member in the disability sector and we are pretty familiar with the operations of the NDIS. What we would like to cover today is kind of our view of the frame of the report, we obviously would like to talk about workforce and your question about rebuild or renovate. We have some views about PHNs, which is in our report and we've got a couple of other matters if we have time that we would like to address, if that's okay. So I might ask Leon to give you our view about the frame of the report.

MS ABRAMSON: And can I just ask for the benefit of the participants and you've been very helpful so far, with the acronyms, if you'd be kind enough to spell them out, which you've already done. Thank you.

MS WHITE: Thanks.

MR WIEGARD: Okay, thank you. Leon Wiegard, assistant secretary, Australian Services Union, Victoria, Tasmania branch. So we thank the commission for their draft report. Just some overall observations. So the psychosocial community workforce is in crisis. Both state and federal governments have removed hundreds of millions of dollars of funding as the NDIS was rolled out. In Victoria alone, 1,300 community mental health workers have lost their job and that's just from the state government funding cuts alone.

The NDIS only covers about 10 to 20 per cent, that's where 20 per cent is being very generous, of those with psychosocial mental health challenges. So in short, the NDIS is not a great fit for those with psychosocial mental health challenges. The participants our members see have serious mental health challenges but are considered to be in recovery, not disabled. And as such, the NDIS is not a great fit.

The work ASU members do links the mental health system together with the participants without the asserted outreach, which was just mentioned before, and the linkages to the community and to employment and then the rest of the mental health system (indistinct), but they're the sort of services that our members provide that are being cut.

We believe that the community psychosocial sector needs to be built up and not torn down. We further believe that the system is, as a structure at the moment, almost guarantees that those with mental health challenges have nowhere to go until the mental health issues are so acute that they need the support of clinical services. This is both traumatising for the participants,

it's very expensive and as we've just said, we've had thousands of really experienced, qualified, passionate mental health - community mental health workers who have lost their jobs.

So we think that we need to put an absolute priority on the early intervention and recovery space, not just provide ongoing clinical supports to those who get unwell enough to need them. We hope that the commission can recommend as part of its ultimate findings that we should put a primacy on early intervention and recovery based systems and not treat the community mental health space as an afterthought, as it has been treated in the past in the way it's providing funding, when you've got some cutting it when you save some money.

So we hope that we can have a bit of a rethink about the way that the system is structured in itself and not just put all of our eggs into the (indistinct) basket.

MS WHITE: So that has played out in other states and Robert, exactly the same thing, and we put an example of one provider in South Australia, how they achieved significant numbers of jobs. Robert works for another provider and they are struggling on I guess in relation to the work that they do. I might ask Robert just to give you an understanding of how they are struggling on.

MR HABEL: Sure. I've worked in the sector in a number of outreach mental health programs, we do psychosocial, strengths based, recovery-based work. I've worked there for 19 and a half years and I've read the report but I couldn't find my job in the report. That was the first point I quickly wanted to make. There's psychiatrists and mental health nurses, peer workers, but no community mental health workers, no support workers or no psychosocial rehabilitation workers, which sometimes is what the title is called. So I'd love to have my profession acknowledged in the report and in South Australia there's hundreds of hundreds of community mental health support workers working in that field every day.

In the organisation I work for and others that I do know, we've been struck with funding cuts and the elimination of programs like PHaMs and PIR. We've also had state government cuts of 25 per cent for our psychosocial programs for state-based services. And that means a reduction of a large number of people that have had to take voluntary redundancies. So we're losing well experienced people that have been around for a long time, that have got those relationships with our clients.

We're finding that long term relationships with people with psychosocial needs is the best way to work because it keeps them out of hospital, it's a good early intervention model as well and to go to an NDIS only funded service is impossible to structure workforce around that. It's not like for like funding and it's certainly not like for like work philosophically.

While NDIS is terrific and great for a number of people, we're predicting, as Leon said, up to 20 per cent of our people will qualify and get NDIS. We've got 80 per cent of people that we support won't qualify for the NDIS and it's probably not suitable for them anyway because it's a deficit model, it emphasises your incapacities, where a psychosocial outreach model works with people's strengths, their ability to recover and to work alongside people on a recovery based framework.

So we're having difficulty at the moment along - we've got a lot of NGOs in - (indistinct) got a permanent workforce, that is well-funded, it's well paid and we're struggling to find funds for training and for supervision. Without supervised small teams with collegiate support, it's very difficult to provide good services for the clients that desperately need them. Thank you.

MS WHITE: So certainly on workforce, Robert's highlighted one of our key concerns that is in the mental health workforce section, it doesn't talk - and we're cognisant that there is a chapter about psychosocial issues but the workforce actual chapter does not detail the sort of work that is done by significant numbers of our members and if we had a criticism and/or suggestion, we would like to see some - that expanded significantly so that there is some. Because what we find is that there are numbers of workers in this - performing this work but the recognition that they get, you know, and the acknowledgment of the work is sometimes overlooked.

We've made a submission to the joint standing committee about this in 2018 and expressed our significant concerns about PIR and PHaMS being disbanded and we supported the recommendation that you highlight in the joint standing committee report and the way in which it finally was extended, those schemes were extended, was knowing the damage which is highlighted in our submission, of course knowing the damage to the workforce which has not recovered. So we certainly would like to see a workforce, and we understand that peer to peer there is a specific recommendation in relation to peer to peer and we have a couple of comments on that if we might make that, and Liam has been a peer worker and might just have a few comments.

MR DOWSETT: I might just say that - to remember the not for profit sector or the community managed sector when talking about peer workers because there's a lot of peer workers in that area and often they get excluded where the training - for training and things like that. I know that because of the pressures on the community sector training is one of the first budgets to be cut and I know that if we had some sort of (indistinct) training system where the peer worker had access to make decisions and empowering the peer worker to make decisions about their training, including not just peer workers but all workers in the sectors that would be a very enabled tool to keep the skills in the sector. Also it mentions in the report seeding - possibly seeding a professional organisation.

Again, that would have to be open as well not just to peer workers in the hospital system but also peer workers in the community sector. They often get overlooked for training and things like that. I know Being is a very good program for peer worker training and peer workers and days for peer workers in the hospital system to discuss their ideas and things like that. There's (indistinct) specific for people in the hospital - peer workers in the hospital (indistinct).

MS WHITE: And we - there are a range of peer workers in a variety of areas, not just mental health and Leon has some significant experience in that in other sectors and we just might - and he might just share that with you briefly.

MR WIEGARD: Yes, I think - I mean the idea is an interesting one about setting up a professional body and we would argue that we are a professional body for peer workers across the community services sector. We represent peer workers across a whole range of different areas. We have members who are (indistinct) workers who have - who have a whole number

of other issues with (indistinct) so we see that it would be interesting to see the relationship that you see between professional organisations funded separately because a lot of the issues that we see are industrial in nature. You know, it's the peer workers are employed and then there industrial issues that may stem from the challenges that they may face and that's where you'll often find this conflict.

That there needs to be that industrial overlay between employing a peer worker and their ongoing satisfaction of work. So it'll be interesting to see how you would see that that which is (indistinct) there'll be (indistinct words) a number of worker who are already members of ours and we represent on a daily basis.

MS WHITE: Can we also speak I guess about PHNs and how that's been operating and how that has - the sort of failings that we might have seen as - and I might ask Nick to - just because he has experience with that, I mean PHN.

MR FARR: Yes. Thank you. So in 2019 federal PHaMS funding ceased and that meant that most of - -

MS ABRAMSON: Would you be kind enough just to say PHaMS is for the transcript?

MR FARR: (Indistinct) programs that (indistinct words) - -

MS ABRAMSON: Partners.

UNIDENTIFIED SPEAKER: Personal - -

MR FARR: Helpers and Mentors. So many of - so most of my colleagues moved on by then and found other work. There was - like we had skeleton crew that hung onto that end date. I was - I was one of those people and I was also lucky to get a role in one of the PHN funded services. So I was able to support consumer (indistinct) transitioning from the funding stream that they were on to whatever funding stream they were eligible for, whether that be continuity of support or psychosocial transition or the psychosocial support service. I guess we were lucky that we were able to form a team that was quite experienced and therefore were able to hit the ground running, but what we're just experiencing now as there's more demand that recruitment has been - it is very difficult to find high quality candidates for these positions as they've, you know, started looking for new work way back in 2016 when the NDIS started rolling out in different areas.

I guess another issue is we're working with, we're working in a much larger catchment area with a much smaller team, and we're travelling a lot more, and I guess when it comes to PHN I think we're really lucky that the relationship is good, but what we're seeing is that there are different eligibility requirements from different PNHs, and just for one example in one PHN catchment the consumer will have to (indistinct) NDIS access and be denied before they're able to enter service and in others that's not the case. I guess another issue that we're seeing is that there has been some delays to fund some of these services, but the expectation is that the services are up and running quickly so there's been discrepancy there.

MS WHITE: Thanks. So the other on this matter that you asked organisations whether it - whether you prefer the (indistinct) or renovate model, and we have a view on that. I might ask Jan maybe to talk about the funding model first and then Leon will talk to you about that view about the rebuild or renovate.

MS PRIMROSE: Thank you for the opportunity. The concerns that I raised reflect the concerns that have been raised previously and in fact (indistinct) concerns that are raised in your own report, and that is when we look at whether to rebuild or renovate. The concern relates specifically to linking funding to existing medical funding. So that it talks about funding allied services based on funding that already exists, and the concern would be threefold. The first thing is the commitment to a medical model of psychosocial support, whereas we know that a lot of the people who work in psychosocial support in fact are professionals that don't come from a medical background.

The second thing is that linking an already underfunded sector to funding for only medical professionals is going to exacerbate an inequity that already exists, so particularly in regional and remote communities or in communities where they don't have GPs who bulk bill, and when there is a high level of people with mental health issues that either can't or don't access allied professionals or GPs or other medical practitioners. There will be no - that provides no basis of assessing the need in that area, and the third is that because psychosocial support is aimed at recovery and is a strength based approach rather than a medical deficit approach, it means that many of the people who are already accessing - who are accessing services other than medical services won't be identified.

So it's not so much a comment on whether we would prefer rebuild or renovate, but if there's a flawed funding model it's going to exacerbate an already underfunded system.

MR WIEGARD: And I think some of the more practical considerations are also that, you know, we don't - or (indistinct words) when we say that - when (indistinct) say the social sector is in crisis and we have lost a huge number of workers and there's been a number of people who have lost those services. So we see that there needs - and we understand that there has been some stop gap funding but that's really just tinkering round the edges. If we're going to - I don't think there's many people who would say that the mental health system in this country is working particularly fantastically well. So a rebuild is something that we have to absolutely look at. But I think we need to have some stop gap. I think one of the recommendations that we have is that Personal Helpers and Mentors, Partners in Recovery (indistinct words), these programs we know have worked in the past, being refunded until such time as we understand what that rebuilding is like. And what we're concerned about is if we are going to spend the next year or two picking it apart and rebuilding and then working out what funding ought to be, we'll be losing the services.

I think one of the reasons why Nich's service has worked particularly well in Victoria is there wasn't much of a gap between the loss of the funding and the state funding that came through to replace some of that. And they were able to transfer the workers just directly from one funding scheme to another. And so they kept those professional workers.

The longer it takes for us to rebuild the system, the more we lose those people who are already working. There are many who are being lost and moving to other areas like alcohol and other

drugs who probably won't come back because the system is not – you know, because there's been so much change and so much chaos. That's not exactly the system that people want to come back to if it's going to take another year or two. So, some of those practical examples, yes, help to rebuild, but we think there needs to be a stop gap (indistinct).

MS ABRAMSON: Can I perhaps ask you to pause there because we're very keen to ask you some questions.

MR WIEGARD: Yes.

MS ABRAMSON: And we're also working on the basis that you'll be providing a further submission and having further conversations with us. Stephen, did you want to ask something for (indistinct)?

PROF KING: There are a number of things that I could ask. I just want to clarify actually something that (indistinct) mentioned. You talked about a portable training system for peer workers. Then for community health workers, you made some comments on – which I wasn't quite certain about. Were you talking about the training system for community mental health workers needing to be – improvements there, accreditation? Do you mind just expanding a little on that?

MS WHITE: Sure. We commissioned a paper done by the Australian Institute which we didn't submit, but we're happy to do, about this for their – for the NDIS and we gave that to the Joint Standing Committee and the (indistinct) Government for quite a while. What we see is that the training should attach to an individual - well, what we put is that it should attach to an individual and that based on the number of hours that they work in a – in a - in the sector. I'm happy to put that to you – to you - - -

PROF KING: That would be good, yes.

MS WHITE: And it is not just for peer workers. But we pitched it in relation to disability workers more generally, but it could work potentially in other sectors. So it really is then for – for the worker to amass the hours and sometimes the workforce currently, particularly in disability, people have multiple jobs and so it doesn't make sense that – well, the (indistinct) would like to see every employer do it by the funding model. Particularly in disability, then – and growing elsewhere. It means that – that is the first thing to go. Whether it's for peer to peer workers or for anybody.

They don't get the training. And that is – you're not going to have a highly trained workforce that have got the – can – people that are going to stay in the sector unless you can attach to them – unless you give them training and give them some sort of career path. And so that - it could potentially be adapted here and we have been – the Joint Standing Committee of the NDIS recommended it to the Government, that this is something they should seriously look at. So we're happy to put that, too, because we can see it elsewhere, because what's happening is that on funding training, they're not funding any work or anything under the NDIS.

And they're putting people on, as our submission says, on a lower level on their social community services award. Some might call that wage theft. I probably would, too. It's a

pretty despicable thing to put – you know, that people are performing work at one level and being paid at a much lower level. And not getting trained, so we're happy to put a supplementary submission that goes to that.

PROF KING: That would be good.

MS WHITE: Because we've done a lot of work on that.

PROF KING: That would be fantastic.

MR DOWSETT: Can I just quickly say - that I was just – with the peer work, I was just comparing people in the government hospital system. What training they get there as to what you get in the community based mental (indistinct).

PROF KING: Yes. I understood that. It was more the order.

MS WHITE: Yes. And we've certainly done more work on the (indistinct).

MR DOWSETT: Yes.

PROF KING: Okay.

MR COSTELLO: Do you mind if I say one thing?

PROF KING: Please.

MR COSTELLO: And I'm very aware of your time, is at a premium. One thing that I suppose I didn't really see and haven't heard so much as just the maybe lack of emphasis on care and treatment for trauma and it's under the NDIS again, there aren't really pathways for somebody who, in my work probably 80 per cent or more, the people I would see have mental health difficulties.

But also 80 per cent would have experienced childhood trauma or complex trauma and as a result of that, would probably have alcohol and other drug or other addiction. It's sort of all bound together. Because NDIS requires – not only does it require you to admit that you have a disability that's unchanging and not – without a possibility of recovery, it also requires you to say that all of the therapies or all of the treatments have been tried and so I have to – yes, the possibility of any kind of recovery is not there, because if it is, then that is - becomes a medical issue and it becomes a responsibility of the Department of Health.

So as a result of that, if I have those three things: trauma background, AOD stuff, mental health difficulties going on, the only recourse for me for some kind of treatment is medical treatment, which works for some people. And it does work for a lot. Or if I'm lucky and I have a care worker who maybe points out to me that there is a GP care plan system whereby you can have a GP mental health care plan and you have access to maybe six, or maybe if you're lucky 10 sessions with a psychologist or a counsellor, it's very likely, that counsellor is CBT trained, which is cognitive behavioural therapy, works for an awful lot of things, there's great evidence to suggest it does.

There's no great evidence to suggest it works for trauma. And honestly, I can't overestimate how important the kind of levels of trauma that there is in the people that I work with and that's not being catered for. So that means more trained trauma therapists and that means a kind of a systemic shift in looking at – because if I'm a trained – if I'm a, you know, a therapist and I want to be trained in something that I believe is real and useful, I'm probably going to want to go to trauma therapy.

MS ABRAMSON: Can I just - - -

MR COSTELLO: But if I want to make a living, I'm probably going to be going to CBT because that's the system.

MS ABRAMSON: Can I just ask - - -

MR COSTELLO: Please.

PROF KING: I will just give my apologies again, because I do (indistinct).

MR COSTELLO: Yes.

MS ABRAMSON: It's not that – we're just a bit mindful of time and as I said, we're fully appreciating that we will have further discussions with you. One thing I did want to ask was about the mental health community workforce. One of our difficulties with the report, we never wanted to give the impression that it was all about the clinical model, but when we looked at it we could see what the clinical model looked like and one of the difficulties with our team was that they – it's such a broad category, these community mental health workers.

So we really need some help from you in working out, well, who are these people? What do they do? What is your data around that? So we would – you know, and what's being measured - we'd really welcome that in a submission. It's an area where we need some help.

The other issue I would ask you is that what would be your criteria for access to psychosocial supports? Because at the moment we think about them, well, clinically over here, you have this diagnosis and you need X and Y. So we're very open to your views about what criteria you have around access.

MS WHITE: You said you wanted a comment on that last submission now or do you want to - - -

MS ABRAMSON: That would be – no, well, both. If you're able to comment now that would be helpful.

MR COSTELLO: There are kind of gaps in terms of - there's – there are programs that exist where if, for example, I have had many hospitalisations, mental health hospitalisations, I'm probably relatively well-covered by what was mentioned already, HASI, which is in New South Wales at least, or a very – another (indistinct) called EACLSS which is essentially called

community living support. But for – to have access to that, I need relatively recent and many hospital admissions.

If I'm struggling with mental health, but I don't have those because of the kind of, you know, death of PHaMS and now PIR as well, there's a big cohort of people who are out there who don't have casework support and who neither have the kind of support that allows for connection and community. So I work with lots of people who might have been previously homeless, now they're housed, have mental health difficulties but not enough to get onto the radar of community mental health and case management.

So to answer your question, I think there needs to be referred pathways where you don't have – you don't have to have a lot of admissions and psychiatric diagnosis but you are clearly struggling with mental health and access to perhaps a case worker but also access to just recreational stuff; connection. Because the enemy of positive mental health is isolation and loneliness and lack of stimulation. All those things.

MS ABRAMSON: Well, we welcome some thoughts in that area. The other thing that I wanted to ask about before I pass to my colleague was I think Leon, you mentioned a primary early intervention and prevention. So I'm just asking in a practical way what type of recommendations would you be looking for us in that area? I may have unfortunately got the wrong person but I think it's (indistinct).

MR WIEGARD: No, that's okay. I think I can throw something like that to Nich. But I think we've seen funding (indistinct) but I think it goes to what was just said before about people who are, maybe right at the very start and maybe just have some challenges but don't have a diagnosis and yet there are no supports available there, and so you wait and you wait and you wait until that person – until the mental health challenge gets so acute that they end up in a clinical setting somewhere.

We think that there needs to be more funding at that early stage in order to provide those supports and those linkages so that people don't end up being traumatised and end up in a clinical space which is traumatising for the participant, also, really expensive as well, and we think it's a false economy, because you're taking money out of that early intervention space in order to provide funding into the – into the clinical setting.

Nich, did you want to add anything?

MR FARR: Yes, I just want to add that the eligibility of criteria for our service is we know it's relatively low. You don't have to have a formal mental health diagnosis, you just happen to have significant mental health issues that is having an impact on your psychosocial functioning.

I guess – and so, folks can self-refer. So I've referred (indistinct) from seeing a 1300 number and making that phone call. Some recommend through GPs. I guess the issue with that and that the dismantling of the workforce is that we've gone out to a – to a three to six month wait list in three months just because we don't have the capacity to take on all the referrals that are coming in. So the wait list is already quite significant. Unfortunately, we won't be able to provide support until other people are exiting.

MS ABRAMSON: How do people find you? You just talked about referrals so where do the referrals come from?

MR FARR: Yes, so we did a little bit of service promotion. So we went to different local area community centres and community clinics, but a lot of (indistinct) so one might get support through our service and then talk to their friends and – but also, we have a lot who come through GPs and - - -

MS WHITE: And Rob, did you want – you’ve got something to say about that? You’ve got something similar?

MR HABEL: Yes, I can only reiterate what’s been said. But one – one of the great things about the Personal Helpers and Mentors Program, the federal funded program and similar programs in the State was they were basically self-referral programs and what that meant was the programs that my agency had had before then, you had to have hospitalisation. You had to have a care worker through mental health and you pretty well had to have a mental illness that was treatable by drugs.

Now, this excluded people who were borderline and other personality disorders, anxiety, depression, post-traumatic stress disorder, people suffering from refugee traumas as well.

So a self-referral program, I think, is essential both at State and Federal level and that is some – that’s one of the access that’s been shown up with this collision between the over-expectation that NDIS will fulfil the needs of everybody in current mental health programs.

Clearly, we need parallel funding of programs; NDIS was great for some people. The large amount of people that we support with mental health do far better and they prefer themselves to be on lots of other programs that are easy to access.

MS ABRAMSON: No, I understand you. But, Harvey?

WHITFORD C: Yes. So I think what you’re describing is some of the challenges we’ve heard repeatedly, that this – that the non-clinical spaces which has sometimes got this psychosocial label which means different things to different people as far as we can detect from talking to different groups, is covering a multitude of service types, I guess.

And whilst it may seem like we’re, you know, categorising it, we need some sort of structure or architectural taxonomy that describes these components. Because if we’re going to try and fund them, we’re going to need to describe what they are and who they’re for and why they’re needed and what outcome we’d get from them, et cetera.

Has there been anything you’ve come across that could help us in that regard, as far as the – there’s a further – (indistinct)?

MR WIEGARD: I’m not quite sure. But just to back up your point though, it’s funny, when you talk about members of our – the programs that have been lost and then a, ‘Do work for in Personal Helpers and Mental Services or PIR and the Victorian State Base Emergency Assess

Funding model,' and they say 'Oh, I don't know,' because it's all essentially the same service. I mean, they're doing the same sort of things and so we're really talking about the loss of those linking programs that are sort of things that we've told people to look into in the community.

So we're really talking about the - what they do, not the program model. So I guess that's what we refer to when we're talking about psychosocial is to provide those services, those early intervention and all of the suite of services that we've been talking about, in terms of what that actually looks like, I'm not sure, apart from to whole-heartedly endorse your recommendation 4.1 around finding more funding (indistinct) we'd absolutely endorse that.

I think it's good for employers and it's good for the workforce. It gives them some security and that will be security for the first time in a long time. This is a second that's (indistinct) as I said before. So what that looks like is – if you can perhaps give them a (indistinct).

MS WHITE: Yes. I mean, what we'll do is give you the - we'll give you the (indistinct) because we've got lots of people who work in that area and who've seen things that they've said to us that they think is – that have worked and the services that they provide and there's a commonality between states. And obviously – and we were – our members were absolutely in PHaMS and PIR and so we will turn our mind to that because we have got people who have worked on that absolutely.

You asked a question about the statistics. We'll try, but unfortunately, some many years ago, the ADS stopped looking at those statistics – categorising that this work - - -

MS ABRAMSON: Ms White, you might encourage us to ask the ADS to (indistinct).

MS WHITE: (Indistinct) I have encouraged the previous Productivity Commissions to do so, and so I'm happy to re-encourage and also even raise it directly with the Government because it really does, when you do contracts that are outcome based it would be helpful to know how many people it took to get the outcome and how many have done a lot of work on the Equal Pay case under the (Indistinct) Award which covers our members.

I was (indistinct) gobsmacked that nobody could tell us how many people were working in the sector. Nonetheless, the best - there is some place where you could get that and the best places is – as a model, at least what sort of workforce there is, is the ACT (Indistinct) Long Service Leave. And they have been able to – because - - -

MS ABRAMSON: Because they need to pick people up for the (indistinct).

MS WHITE: They do. They have got it, so they will give you a lesser model and what was surprising in the statistics that they generated is how many people that there actually are. And that would be a good (indistinct). Victoria will have that probably in a not too distant future for some numbers. But that would really help you seeing (indistinct). And that's the best that I've seen.

But we will work – we have made some (indistinct) if you (indistinct) through the equal pay (indistinct) attempt to get back to you.

MS ABRAMSON: Thank you. There's one file I'll ask you to take while (indistinct) I'm sorry (indistinct).

MR WIEGARD: I was going to say there's an independent evaluation on my program, the HASI program. It's (indistinct) program.

MS ABRAMSON: Our staff will be very interested in (indistinct) evaluation.

MR WIEGARD: It's done by New South Wales University, the (indistinct). And it's called the – it's just plainly called the evaluation plan, community based mental health programs, CLS and housing accommodation (indistinct).

MS ABRAMSON: (Indistinct) and kind enough to (indistinct).

MR WIEGARD: Sure.

MS ABRAMSON: So can I also ask you to take on notice, you made a (indistinct) comment about the PHNs and where you see those worked well, what do you think it is about them structurally or people-wise that makes it a (indistinct) interesting. I'm sorry it's been whistle-stopped choice. Send your evidence in.

UNIDENTIFIED SPEAKER: (Indistinct words).

MS ABRAMSON: Thank you. And we'll now adjourn for lunch and be back here at 1.35 again, yes..

LUNCHEON ADJOURNMENT

RESUMED

MS ABRAMSON: Well, I might make a start. If I could reconvene the hearing please and I have some - this morning Commissioner King noted that in an event of an emergency requiring evacuation of the building apparently we evacuate to Hyde Park. Also could I remind participants that we're actually doing a live stream. If you don't want to be in a live stream you will need to not be in the room.

We've also got psychological support here. If at any time anyone feels distressed please contact one of our staff members and Ros is at the back of the room there and we can direct you to the support we have today from Lynne. So having said that could I please ask Mr Bartlett, or Dr Bartlett, to take the stand and to announce on whose behalf you're appearing and where you're appearing from. I should have called you clinical associate professor.

DR BARTLETT: No, that's quite all right. Doctor's just fine.

MS ABRAMSON: Thank you.

DR BARTLETT: I'd like to thank you for the opportunity to be here. I'm representing the University of Sydney and the Woolcock Institute of Mental Research. I come here today with three (indistinct words) a registered nurse, English trained midwife, a PhD from Sydney University and I've worked as a health psychologist in sleep.

So what I'd like to do today is actually present to the (indistinct words) of the importance of sleep across the lifespan and particularly in relation to mental health. So sleep occurs every 24 hours a day and it's a time for us really to chill out, not to be responsible, not to think or feel, and when we don't experience this we are often compromised in terms of performance outcomes (indistinct words).

A symptomatic review of mental analyses, which has just been published this year, found that insomnia is a significant predictor for the onset of depression, 1.3 odds ratio; anxiety, 3.23 odds ratio; alcohol use and psychosis. And the author stressed the need for more prospective studies, long term intervention, and to remember that sleep provokes mood and neuroplasticity. We also know that there's a very strong bidirectional relationship in relation to insomnia and depression and this one is published in 2012 and this was of nearly 25,000 participants so if you get the baseline insomnia is not treated you will end up with depression. If you get a baseline depression and it's not treated you will end up with insomnia.

So it's been a bit shift because prior to 1996 if you had insomnia you just had depression, fix the depression and sleep will go away (indistinct words). So sleep is important across the lifespan, if we start with a perinatal period more sleep is (indistinct) with pregnancy making nausea, morning sickness, increased heat as the baby grows, baby effort unplanned outcome like a long labour or caesarean section, maybe a baby that doesn't (indistinct words) and yet an antenatal prenatal care this warns nothing about the sleep of the mother and there's certainly nothing about sleep with the baby and what to expect and really if you learn about sleep and the difference between quiet sleep and active sleeping babies (indistinct) babies that were sleeping better and what can mothers (indistinct) as well.

So when a baby is born a mother is born who equally needs parenting protection and it's the overwhelming fatigue that keeps with short disrupted sleep and wanting more disrupted sleep, it is so difficult in its first few weeks. I usually describe the first 6 to 12 weeks as a survival course and it puts a lot of stress on family and relationship dynamics and so people are isolated these days without any friends.

We know that postnatal depression occurs in 15 per cent of the population (indistinct words) and we know that if a mother is depressed - sorry, and we know that if a mother is depressed it's an increased risk factor for her partner as well. And we know that we can help this because we've done interventions at Sydney University where we've given sleep interventions for new parents and there's no difference at six weeks because it is a survival course but I - four months' intervention, all were sleeping better, they were less fatigued and they felt as though they were managing the babies better.

So I've watched some of the other presentations by child psychiatrists and the issues of involving mental health nurse training is critically important and I'm totally supportive of all of this. But we also have a lot of babies and young children in long day care. They're tired

and they're not getting to bed early at night so that's another big problem that we have to face. And the role of worry and anxiety around day care, family, school, environments but when we hit adolescents it's the perfect storm; increased homework, staying up late, phone, social media, hormones, mood, plus a certain percentage of adolescents will develop delayed sleep phase disorder where they can't go to sleep till about two in the morning, can't get up to go to school, or university or work.

Adulthood has its own problems as well in terms of sleep; working, maybe studying, travelling long distances, shift work - 20 per cent of our population are shift workers, high pressure jobs, parenting, long hours. Middle age, our bodies start to slow down and don't work as well. Often increasing weight, perhaps the onset of obstructive sleep apnoea and left untreated it's a risk factor for cardiovascular disease, diabetes type 2 and depression.

We also have other significant factors; the role of menopause on our sleep in terms of women and that can be very difficult along with actually having to care for aging parents; costs, worry, all of it very difficult. Over 60 years of age there's increase in health-related factors and we often end up taking a lot more medication, there's a lot of interaction with that that also impacts on the quality of sleep. But we know if we are healthy in terms of exercise, diet, and we need to be stimulated; the prevalence of (indistinct words) and that population is much the same as the general population. That's the big gap.

Increasing age has a more definite effect on our bodies and our brains. We know the critical role of sleep and helping to clear up the toxins that build up over the day particularly in terms of (indistinct words) which is associated with the onset of dementia and that's not been clear from the brain at night during sleep. And there's been very little research in this area until recently. Again there's a tendency to overmedicate our older Australians and to prescribe hypnotics because they don't understand about sleep, that waking is normal. We need to reduce falls and confusion and there was a lovely article in the Australian on Friday about the role of dementia which it seems quite a long paragraph on the role of sleep.

So all of these things that are happening, we've also got a drought and we've all these terrible fires; how can we help to improve better access to mental and (indistinct) help particularly in rural communities. They're financially stressed, there's isolation, there's a lack of access to care, high risk of suicide; all of these impact on sleep and sleep impacts on the way we act and perform. We need to normalise sleep and that means about giving good information out to the general community; waiting it's normal, everybody waits. It's the length of the wait that's distressing. We don't spend the night in deep sleep, we spend most of the night in relatively light sleep. REM sleep is not deep sleep and we have to know all about these things so that we can normalise them.

So in terms of recommendations, sleep being a primary component of all prenatal programs, we have good pilot data on the effectiveness of such an intervention and we need to expand programs that are already there such as organisations such as 3Bridges which is here in Sydney where they train volunteers in providing practical help, shopping, assisting mums to go to psychology appointments, in house respite for mothers to allow them to sleep and supervision of older children and this is so important with people who are isolated. These early intervention critical support of bub and mothers in early months, it's something that we really need to make more use of.

Education on initiatives on how to make good sleep fun to do with school age children. There's a paper that's just been published in Ireland about an intervention for school age children and it's all based on Australian research which is very interesting because we're not making enough use of it. We need to train practice nurses in the community, particularly in rural areas and practice nurses have wonderful motivation skills. In a pilot study we trained practice nurses to do cognitive behavioural therapy for insomnia and there were significant improvements in sleep outcomes at three months and (indistinct words) caught up at six months. They were also well supported by GP practices which is another important component when you put anything into practice and we need to make sleeping an integral part of psychology training because it isn't at the moment and we're not working on a joint venture with the Australasian Sleep Association in psychology modules on insomnia.

GPs still do not refer their patients to psychologists, they still - on average 94 per cent will give them a sleeping medication and this really hasn't changed from a paper that was published in 2010 and a follow-up in 2017 which is of concern here. We need to use other health professionals such as pharmacists because they can often be the first step and put information around sleep and many people go to the pharmacist before the GP or anybody else and so we have an ongoing program of that as well.

In terms of the aging brain, Brain and Mind Centre and University of Sydney and Woolcock we have intervention programs for interventions with Parkinson's, healthy brain aging because we know it's particular in our Parkinson's patients sleep is greatly compromised but also mood is as well. So overall we need to value sleep, set aside time to sleep yet achieve a realistic balance with our family's work and use the night time to let go of the day, not to worry, not to plan or connect with others through our phones and that's a big ask. But we are very adaptable and we can do this with good information and a lot of support. So thank you for this opportunity.

MS ABRAMSON: Thank you very much. I'm interested in where you spoke about what could be done in the perinatal phase and the type of training and support. So just interested in a bit more detail about that.

DR BARTLETT: Well, I think most ante or prenatal clinics there's very little information about sleep. There's almost no information about sleep post-delivery and a lot of people do not understand that babies are very active and very noisy when they're in active sleep, if they're still asleep and they do not need to be picked up so if you're continually picking up a baby when it's having active sleep then you're disrupting the sleep patterns and also disrupting calmness.

MS ABRAMSON: It's not my area of expertise so I may say something that you'll say, 'Oh no, that's not right' but we do have a lot of emphasis now on mothers attending sleep schools with babies but the intervention you're talking about is prior to a mother actually saying, 'I actually need some help settling the child'.

DR BARTLETT: Yes, so prevention is always a really good opportunity if we can possibly do it and sleep schools per se are often extremely expensive and a lot of the population are unable to access that.

MS ABRAMSON: Can I just ask you on an unrelated point; have you quantified the extent to which lack of sleep is contributed to depression, so do you have some sort of statistical analysis around that?

DR BARTLETT: In terms of postnatal depression it's probably about 15 per cent of the population and probably as high as 35. What we know in terms of the actual percentages in general population insomnia, it's quite (indistinct words) depend on the population that we're looking at but it can be, you know, 12 per cent (indistinct).

MS ABRAMSON: Thank you.

PROF WHITEFORD: So just on that, has there been similar work for depression other than postnatal depression or perinatal depression?

DR BARTLETT: A considerable amount of work between sleep and depression, so in some interventions where they've just looked at individuals who have both insomnia and depression and they just treated the depression, the insomnia stayed the same and the depression came back again. When they've looked at both insomnia and depression together they've had much better results and it's now suggested that you work with the insomnia first and then the depression in terms of interventions.

PROF WHITEFORD: Right, because they often go together - - -

DR BARTLETT: They do go together.

PROF WHITEFORD: And I guess the traditional way of looking at insomnia is that it's a symptom of the depression but what we've heard in this inquiry and what you're saying is that it's bidirectional.

DR BARTLETT: It's bidirectional, yes.

PROF WHITEFORD: Yes, okay.

DR BARTLETT: But it's interesting if you've only treated depression then the depression comes back whereas if you treat the insomnia and the depression you have much better outcomes.

PROF WHITEFORD: Okay.

MS ABRAMSON: Thank you very much.

DR BARTLETT: Thank you.

MS ABRAMSON: Could I please call Ms Chalmers. And if you'd be kind enough to say who you are and where you're from and also invite you to make an opening statement if you wish to do so.

MS CHALMERS: Thank you. Thanks for having me today and thanks for all your attention and time that you're taking to consider the speakers. My name is Lisa Chalmers. I am here representing School Nurses Australia. I'm currently employed as a school nurse at a large co-ed school in Sydney. I believe school nurses are one of the keys to addressing the issues raised today particularly by Jack van Bilsen at the wellbeing in schools presentation earlier today and I think it's a lovely (indistinct) from this speaker just before talking about sleep because I certainly know that Chris Seton, who is one of the experts in sleep in Sydney, says that (indistinct words) symptoms of depression that adolescents exhibit could be deal with by getting them good sleep, hygiene habits, so I think that's really important, thank you.

I would like to propose the role of school nurses as a significant cost effective primary health care measure in addressing the mental health concerns of our young people and their families in Australia. If we are able to identify these students and their families before they fall of a cliff, so to speak, the outcomes for our society as a whole would be remarkable. School nurses are in a unique position for the early detection and implementation of support for those students who are suspected to have poor or deteriorating mental health. Additionally, the role of a school nurse provides strategies in relation to good mental health and sleep hygiene which impacts mental health significantly in young people.

Often students present with somatic symptoms that are the first indications of mental illness to the school nurse so we're seeing them on the frontline. A thorough mental health assessment is always part of a school nurse's assessment. School nurses provide referral to appropriate services, school nurses work collaboratively with school counsellors, teachers and pastoral carers and we liaise with parents and guardians as is appropriate.

Looking at models of care throughout the world we see that most Scandinavian countries, the UK and the US all have well embedded school nurses integrated into their schools. I am very fortunate to be the manager of a health centre at a large private school in Sydney. I have an incredibly forward thinking very supportive principal and executive team and I see firsthand every single week the value of my role for the students at our school. At the same time my heart breaks for what this could mean for schools in less fortunate areas than my own.

What does this role look like in my school? Assessment and flagging of students and staff at risk or showing signs of deteriorating mental health, early referral of these students to appropriate services and supports. Our health centre is a safe place for timeout for those students that need an extra support during a school day. We participate in the student's support teams which is a weekly meeting between the school nurse, the counsellors, the heads of the school, the pastoral team, to identify any students at risk or concerning behaviour and develop an action plan early. Self-harm management in the everyday is dressings and ensuring that there's a safe plan for these students.

Just I guess a snapshot of the last week in my work life and this is just the mental health that I can just quickly think back on. I've managed several anxiety attacks, I've had one threat of suicide where an ambulance was called, I've had several self-harm presentations where I undertook physical dressings of their wounds and checked that their support systems were in place. I participated in a meeting to address a school refusal anxiety concern for one of our Year 11 girls and her family. I administered psychiatric medications to several students throughout the school on a daily basis. I managed an epileptic seizure which consequently

unravelling into a family situation of domestic violence and alcohol abuse. And I provided ongoing support for the boarding community which includes several Aboriginal Torres Strait Islander students on scholarships who (indistinct words).

And this is all at a privileged private school in Sydney so there's never a dull day but it also highlights to me just how needy these sorts of roles are. My proposal is funding for school nurses in every school in Australia as a cost effective frontline measure to address mental health concerns in school age children. And I'd like to finish with a quote from NASN which is the National Association of School Nurses in the US who are far ahead of us in Australia at having these roles. School nurses serve a vital role in the school community by promoting positive mental health outcomes in students through school community evidence based programs and curriculum.

As members of interdisciplinary teams school nurses collaborate with school personnel, community health care professionals, students and families in the assessment, identification, intervention, referral and follow-up of children in need of mental health services. In addition school nurses serve as advocates, facilitators and counsellors of mental health services both within the school community and the inner community. School nurses also offer themselves as a resource to learn and strategise with staff to prevent bullying and promote a safe learning environment in the student body.

School nurses are uniquely positioned between policymakers and the student body as caregivers, advocates and experts. This vantage point affords the school nurse the ability to identify and intervene with at risk adolescents as well as lead in developing a prevention policy. Mental health is a key component in children's health and development. Children need to be healthy in order to grow, learn and lead productive lives.

MS ABRAMSON: Thank you, Ms Chalmers. I've got two questions I wanted to ask you. First of all, we received evidence at the Commission that, and we put it in our report, trying to get access to child and adolescent psychiatrists is incredibly difficult so I'm thinking about your ability to link the student with services outside of the school environment and what your experience of that has been?

MS CHALMERS: Yes, it is very difficult and there are long waiting lists and we utilise a number of pathways I guess for our students depending on their situation. Some of it is actually seeing them to the emergency department, using private counsellors and psychologists and psychiatrists and also we're fortunate to have school counsellors at our school so they also work together with the students and the families but it is very hard to find good appropriate supports, yes.

MS ABRAMSON: Can I also ask you to - they're related questions. One of the issues is around stigma. Now, I'm going to make an assumption and you can correct me if I'm wrong but I'm assuming because you're the school nurse no one would know why a student had gone to see you so that would be part of why you can provide that support?

MS CHALMERS: Yes, absolutely and we often find that the students will come to us before they'll seek other services and that's why it is so critical for us to do a really good assessment of the whole student when we're just seeing them for a sore throat or a headache, yes, because

often (indistinct words) asking something else.

MS ABRAMSON: Can I also ask you about your ability to train in mental health. Have you done like additional qualifications or something to help you with that process?

MS CHALMERS: Yes, I have a Master's in public health but I also - I've done the mental health first aid training course. So that's - and, as a nurse, we have a whole component of mental health training in our undergraduate as well. So, I mean, I think, actually, school nurses probably need to have more. But, we do have a fairly solid starting point, yes.

MS ABRAMSON: And how do you relate to other wellbeing teachers? I think you said before that you actually have a process on a weekly basis where you meet?

MS CHALMERS: Yes, we do. So it's - we have a meeting to address students of concern that sort of get flagged from all over the school. And we sit down as a team and talk about those students and how best to manage them. Yes, so we have the counselling teams, the nurse and we have the pastoral carers and the heads of the departments if need be.

MS ABRAMSON: One final question - I'm sorry Harvey - how do you manage that difficult issue of consent with adolescents? Because we've heard this morning some very compelling evidence about parents who have wanted to be involved in treatment and couldn't be and guardians who weren't able to support the person the way they'd like. How do you go about that issue with people who are under 16 - and strictly speaking, by the law, probably need parental consent - how do manage that?

MS CHALMERS: It is very tricky. And we walk a tightrope. And - where do I - it's - I guess it's a case by case basis, really. And we work collaboratively to try and work out what's the safest for the students, because for every caring family and parents that we've seen this morning, we - I mean, we have a 16 year old girl who has been prescribed medication for her depression and her parents have refused to allow her to take that medication. So, we have two sides. So, it's difficult.

MS ABRAMSON: All right, thank you.

MS CHALMERS: I wish I had the answer.

MS ABRAMSON: No, no, that is helpful. Thank you.

MS CHALMERS: Yes.

MS ABRAMSON: Harvey?

PROF WHITEFORD: So, just on the lack of access to child psychiatrists - I guess one of the issues for us is the connection between the mental health services provider that are in school versus those (indistinct) community. And I'm sure that varies depending on the community. But, have you got an established network of health professionals in the community that you can refer to, or that you can seek extra support or clinical?

MS CHALMERS: Yes, we do, absolutely. And certainly with - I mean we, our whole aim is to capture these kids at the beginning and try and nip things early. But certainly as their mental health deteriorates then progresses we absolutely use outside services and we have - essentially - we have a list of referrals and we absolutely involve the families, the parents and encourage that it's a family - and often, yes, it's looking after the family. It's having - a healthy family equals a healthy child too, sometimes. Sometimes not. But, we try to make sure that it is very collaborative, yes.

PROF WHITEFORD: Last question then would be - is there a support network for school nurses? By the sound of that the - what I would call - the case mix of work you've got. It's a full spectrum of physical and mental health issues that you could come across.

MS CHALMERS: Yes, absolutely.

PROF WHITEFORD: And, from what you said, perhaps, you know, asking one nurse in a school to cover that is asking too much often. But, do you have your own - or is there a structure or a support for you? Given you're the nurse in the school and you're not working in a hospital or a healthcare setting where there's senior nurses around. How do you manage that?

MS CHALMERS: Yes, well it is very much. I know a lot of - I'm fortunate I have other nurses that I work with. But it's a very isolating role. So, there's the School Nurse's Australia Association, and then each state has their own associations as well. And we endeavour - I'm the president of the School Nurse's Australia - and we endeavour to - part of that role is to really support school nurses in Australia. We have a two day conference annually where we get speakers in to education and upskill the nurses, along with lots of, sort of, social debriefing events, really, to collaborate and share experiences, yes.

PROF WHITEFORD: Right. But there is no - from what you said before, a lot of the support you get is within the school, where you have regular meetings with other senior staff in the school.

MS CHALMERS: Yes.

PROF WHITEFORD: But, professional nursing supervision wouldn't be routine.

MS CHALMERS: No, absolutely not. And I think that's - one of the goals is to develop a recognised pathway, like they have in the UK, for a school nurse. So, in Australia we have, say, a midwife program. Well, you'd have a school nurse program where nurses get specifically trained to be school nurses. And that, obviously, we'd incorporate a significant mental training component. Yes, so that's on our wish list of goals, yes.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Ms Chalmers, we encourage you strongly to put in a submission.

MS CHALMERS: Certainly.

MS ABRAMSON: That would very helpful for the Commission.

MS CHALMERS: Yes, I would be very happy to.

MS ABRAMSON: Thank you.

MS CHALMERS: Thank you for your time.

MS ABRAMSON: Could I please call Orygen Professor - I'm going to pronounce your name wrong, I'm sure - Professor Killackey? Thank you. And if you would be kind enough to announce your name and organisation for the transcript, and I also invite you, should you wish to do so, to make an opening statement.

PROF KILLACKEY: My name is Eoin Killackey and I'm from Orygen. Thank you for having me - and, I guess, Orygen - here today. And thank you for the draft report that we've been able to read and comment on. Over 30 years now Orygen's been developing, researching and translating holistic and evidence based early intervention to transform the lives of young people and their families and to deliver significant social and economic benefits to the Australian Community. For that reason, we are particularly welcoming of the draft report's prioritisation of prevention and early intervention. As we were with the Commission's acknowledgment of the role of underinvestment in early intervention and prevention contributing to the poor outcomes currently seen in mental health in Australia.

We're in also in the agreement with the report's focus on holistic approaches that extended to other domains, such as education, employment, housing and justice. We are concerned, however, with the recommendation in the draft report to remove the protection of funding for headspace services and the headspace Early Psychosis program. We understand the headspace office has communicated with the Commission in relation to headspace. So, I'm here today to talk specifically about the headspace Early Psychosis program.

I thought I might start by giving a bit of a history of the development of that program. Because I think it's an important context. So, in 1992 the Early Psychosis Prevention and Intervention Centre was started in Melbourne and this was the world's first (indistinct) trying to create a model for intervening early in the treatment of psychosis. Up until then, people with schizophrenia often received late treatment and quite often before that, it was inpatient asylum based treatment. In 1996, the (indistinct) was founded, which was the first clinic to try to provide identification and treatment of people at risk of developing psychosis. And as these clinics were developed, research went hand in hand with that to understand how we could do this in an evidence based way and to make sure that what we were doing is effective for people.

The research had spread sufficiently that by the early 2000s the UK government invested, I think, at the equivalent of around about \$2 billion Australian dollars at that time to open up 150 early intervention services across England through the NHS. So, even though we developed this, by the time it came here nearly a decade after that, we were already playing catch up to the rest of the world. In 2007, as you know, headspace started and headspace was a primary care platform. It wasn't intended, necessarily, to be a place for the treatment of severe illnesses.

In 2010 I was lucky enough to lead a project for the National Advisory Council on Mental Health, where we looked into the feasibility of establishing an early psychosis model for

Australia. And we did this by conducting a large literature review of the evidence to that point. And also conducting consultations with international and Australian experts, young people with psychosis and their families and other people. That report went to the National Advisory Council on Mental Health, and a couple of years later in the 2012 budget there was funding for - what's become - the headspace Early Psychosis program.

The initial intent of that program - in our report we had set the (indistinct) to be 20 of these places across the country, with the idea that you get population coverage. One service, we're looking at around about a million people each. There was also acknowledged in that 2010 NACMH report that we didn't really know how to translate this model into less population dense areas. And that there would need to be consideration of how to do that. Although, I was re-reading that report in preparation for this, and there's a comment from a manager of a rural early psychosis service back then who said it's really important that we get the full model too. You could actually put an early psychosis on a service in the country, but it wouldn't be a - we need to figure out how to overcome the problems so that the people in the country get access to the evidence based model as well.

When the funding came in the budget it was meant to be a partnership between the federal government and the states, with around about 16 services set up across the country. And I think one of the threats with removing the protection of funding for a PHN is seen in that episode because over the next year and a half, agreement couldn't be reached between the federal government and the states to implement the model faithfully. They'd want to include bits and pieces of it, but not the entire model.

And then leading up the 2013 election, Mark Butler, who was the Minister at the time, decided that there would be nine sites and that headspace could have carriage of implementing this program and would be directly funded from the federal government. The important thing about that issue with the states is that this modelling is not modular. You can't just pick bits and pieces of it. It actually requires all of its elements to achieve the desired outcomes. So in 2014 some services were commissioned. In 2015 we produced a fidelity measuring tool for these services and that was quite useful to them across the ensuing years, because having regular measures of fidelity both allowed them to identify they were doing well but, in particular, it identified the areas where they had performed less well.

And I think, again, it's another threat - if we don't protect the funding around this - because the areas where they were doing less well are what you might call the non-clinical core bits of it. So, things like youth partnership and family engagement and support in the model of community (indistinct) and education. Reaching out for those other bits.

PROF WHITEFORD: So, Eoin, keep going through, but as you go through, do what just can do there for us - give us examples of how that fits with the recommendations for what we're doing here.

PROF KILLACKY: That's all right. I'll probably get to that part. But, I guess, our greater concern about that recommendation of taking away the protection of funding - and this is probably irrelevant of which commissioning kind of model you go with - whether the renovate or the rebuild kind of model - if the money for this model - for the EPPIC - Australian Early Psychosis Model - isn't protected, I guess what we're concerned about there will be whittling

away of the bits of it. There will be less effective interventions provided for people. There's a real threat that the different elements which are now contained in one place and one service for young people and their families, will be contracted out to different providers. Which then creates gaps - geographic gaps - that young people and their families have to negotiate, which they don't currently have to do.

And I guess the other thing that we're sort of worried about is that there's a significant amount of evidence built up now over the last 30 years about the better outcomes that are achieved through this model, and the better economic outcomes that are achieved. And I guess we're concerned that some of that evidence hasn't been considered in the recommendation to de-protect the funding that surrounds that model.

PROF WHITEFORD: So, just, is the - correct me if I'm wrong - the argument is that the outcomes are dependent upon the fidelity adherence to the core model.

PROF KILLACKEY: Yes. To the model, yes. And I think, you know, one the things you could say in terms of the translation of just about every psycho-social intervention, is, you know, there's research evidence for everything. One of the things that we find as things get moved into regular practices - a drop off in the benefit that we see. And a significant part of that is because we don't control for quality of the intervention. If you think about it with medication, every tablet that is produced has got to the, you know, the milligram. The exact same constituent elements. We can't do that with psycho-social interventions. So we need to look to other ways of maintaining fidelity and, obviously, having a fidelity measure like we do for this, is one of those ways of them providing regular feedback to the services, so that they can actually adjust and develop in the areas that they need to.

PROF WHITEFORD: So, within a - however we construct the integrated community mental health service system that we're talking about - the challenge is moving away from the silos which are criticised, in (indistinct). And yet, in the service component, maintain the right quantity and mass and activity base that's essential for the outcomes that we've funded that service for in the first place. I guess that's the challenge.

PROF KILLACKEY: (Indistinct).

PROF WHITEFORD: Yes, and, so, how do we do that?

PROF KILLACKEY: Well, look, I think one of the reasons why we probably went down the track of early psychosis first, as opposed to, you know, other sort of things, is because there is just so much evidence for what to do in that space. Probably more evidence than there is any other area of youth mental health, definitely, and beyond that it's getting a little bit outside of my expertise. But, the idea would be that as develop evidence for the effectiveness of a similar service model for other presentations that would actually build on the system, (indistinct) to be, you know, early psychosis over here and depression over here, that, eventually, this would actually be joined up.

But at the moment, the evidence isn't there for what we do in these other spaces in quite the same way that it is for psychosis.

PROF WHITEFORD: So, just staying with that for a minute. So, currently, what connections exist between the early psychosis services and other components of the health and mental health services?

PROF KILLACKEY: So, in terms of the existing headspace Early Psychosis services, they've all got connections to state funded inpatient units, because that's not a component that they're funded to provide. Some of them, I believe, have got funding to sort of step up, step down, kind of care. They also - you know, different (indistinct) costed for six different (indistinct) have got connections to other relevant, kind of, community organisations that are useful for the services that need to be provided. I'd say though that one of the things that's probably strong about this model - apart from the flies - one of the things that is strong about this model is about its integration of many of those elements that people would have to go elsewhere to find before.

So, for example, in the function and recovery domain of this model, individual placement support is the, sort of, mandated intervention for helping people get to school and work. And I know that in other elements of the draft report, individual placement support has been recommended as an intervention that should be made available through all community mental health centres. This is already happening in the early psychosis programs.

MS ABRAMSON: Can I ask a bit about - or two non-related areas - but the commissioning. Given your strong support for the program, why would it not be the case in a commissioning model that all of the regional commissioning authorities would actually commission the psychosis support?

PROF KILLACKEY: We think there's a varying level of knowledge across the landscape. And, so, you know, some of the PHNs who are currently responsible for commissioning, completely get mental health and probably do a really great job around this. The problem is that some of them don't - and I think we've probably seen this a little bit with the roll out of the (indistinct 2.18.28) funding, where some of it's been targeted and probably quite well spent. And in other places, there's been perhaps a lack of understanding about what needs to be commissioned. And perhaps that's because the model's not quite so clear at the (indistinct). But, also, I think, one of the, kind of, other problems in mental health is that there is a tendency sometimes to put things into set ups which are well-meaning, but not particularly evidence based and which have got very little evaluation of the outcomes associated with them.

I think that's one of the fears that we would have if PHNs or other commissioning bodies were given absolute free reign about this. The other thing that we think might be a bit of a risk around this area is that if instead of protecting the money, and looking to expand to the original idea of getting population coverage, if the money within that measure at the moment wasn't protected, it could actually be diluted and spread out across a whole range of other presentations. And if you didn't have any resources into, then you're just going to provide a very thin service to people, and probably not be able to perform the elements that are currently part of that model.

MS ABRAMSON: Can I go back to the point that you made about education and will people - the PHNs may not know that much about that space. But your brand is very recognisable. That's one of the things that you've submitted very strongly to us. So, why would it be that

your brand would not be something that all of the PHNs would be thinking about the services that you provide? Or, in this case, the RPAs.

PROF KILLACKEY: Orygen's brand or headspace's brand, sorry?

MS ABRAMSON: The headspace brand.

PROF KILLACKEY: All right. Just to clarify, I'm not from headspace, so I probably can't speak so much about their brand.

MS ABRAMSON: Well, your brand.

PROF KILLACKEY: My brand, Orygen.

MS ABRAMSON: Yes.

PROF KILLACKEY: Look, I think if the brand - whether it's headspace or Orygen - was equally strong back when the measure was first budgeted for, and I think the evidence at that time was that, despite the strong brand and despite the strong evidence, there were varying levels of intent to actually implement the model faithfully. And I, you know, I guess our great fear is we've seen that happen then, with fear that it might happen again. And I guess what we've also seen is that in other places - so in the UK there was a bit of a drift away from the requirements of the early intervention of the early intervention services. And what that led to was a closure of a number of those services.

It was only when they introduced the fidelity measurement, and they also introduced some legislation around, you know, the parity of esteem between physical and mental health in the UK, that there was a revival of those services there. So, in other places where there hasn't been that requirement to protect that investment around this stuff, we've definitely seen drifts. So, there's a number of historical reasons and incidents in other jurisdictions, which I guess make us concerned that this would happen again.

MS ABRAMSON: I should apologise. I'm not asking you to speak for other people.

PROF KILLACKEY: No, that's all right.

MS ABRAMSON: Could I ask you though about your individual placement support work that you do. We're very interested in that, as you would have seen from the draft report.

PROF KILLACKEY: What would you like to know? That's actually been the bulk of my last 15 years of work, so I could be here for a while.

MS ABRAMSON: I understand that. Well, let me be much more targeted. We're very interested in it because it does seem to have very good outcomes for the participants. There has been some evidence that it was mainly use - and I may have got this wrong, so I apologise - with people with psychosis. So, it was a narrower cohort. So, given that the Commission is very interested in this, but it's quite an expensive measure, I'm just interested in what type of

conditions - if that's the right word - you would think it would be very efficacious for. And, also, how would we roll it out. That's the other issue.

PROF KILLACKEY: I'm so glad you've asked me these questions. Okay, well the first thing I would say is that, yes, particularly in Australia the research that has been done has been done with psychosis. And I guess that that merit is a lot of the early research in IPS internationally which has been done originally, I think, with chronic schizophrenia and other quite severe presentations. We translated it into youth mental health, where we have the educational outcomes as a component. And, as you said, in the two studies that I led we got nearly 90 per cent of young people with psychosis back to school or work. And we know that over a 12 month period 80 per cent of those people stayed vocationally connected.

Not necessarily what we got them into, but that's not what - you don't want to put people into something permanently - you want them to actually to actually go and do it themselves. So that's great. There's increasing research now looking at the application of IPS to other groups. So, we're running a trial looking at its application in young people with Borderline Personality Disorder. There's a number of trials in the States which are looking at its application in - particularly to veterans - and in people leaving forensic settings. There's obviously the DSS funded trial in headspace, where it's basically getting into the regular community.

The fundamental principles of IPS should actually apply everywhere. So long as you set it up in a situation where there's a care system around it. So, if you can imagine Veterans Affairs in the US, there's a care system around that and it's integrated with the rest of their care, which is the (indistinct). Same with people coming out of forensic settings, it's integrated with the rest of the, sort of, the support that they have as they move back into the community.

How would you implement it? I think there's a number of issues. So, the biggest first issue - and I think we're beginning to find this now with the DSS trial - is purely one around workforce. So we need a training mechanism - because it's not as simple as taking people who have worked and say job support or (indistinct) and (indistinct) there, because there's actually a cultural component you've actually got to get, and a, kind of, a buy into the idea that this is a client led integrated with treatment approach. It's not, sort of, about just getting the people their outcomes so that you can tick a box. And the other thing we've probably done a lot more with in the (indistinct), taking much more career-focused things. So blending education and employment outcomes.

MS ABRAMSON: Yes.

PROF KILLACKEY: So that there's some, you know, real long term benefit to this. I've been thinking a lot in the last little while about a, sort of, stepped care approach to this. Because, we've started to do some really interesting things using online support for training and employment support. And what I probably think is that there are a proportion of people - particularly, let's say, people coming through headspace - and even some people coming into, sort of, more severe settings where, I mean, it's psychosis or whatever they might be presenting with - who can get the level of support that they need from that sort of moderated online, kind of, platform. And I think that we should be doing a thing where we give, sort of, everybody a trial of that sort of (indistinct), that people who don't succeed with that move on to a greater level of employment support.

And one of the things that came out of the last trial that we sort of did is a suggestion that you can upskill clinicians quite significantly. So that - and I think part of it's an upskilling thing, part of that's a changing of mindset so that they actually begin to believe that vocational outcomes are possible for their clients. And they can transmit that belief to clients themselves. Because I think there's a certain amount of self-stigma which gets in the way of people's vocational recovery.

And then the highest level I'd say then are these IPS workers, who are essentially specialists within this system and who work with the people for whom those other levels of support haven't worked. I guess the only other sort of thing I'd sort of say in your recommendations around that, was a question about at what level should this be funded. My preference would be that it remains funded at a federal level and money transferred to - whether it's the commissioning bodies or whatever. So that the governance of the IPS work and the rest of the clinical programs is a single governance. But the, you know, the area of government that's got the most skin in the game of vocational stuff are the people who pay welfare payments. And, I think, that's probably the appropriate level of government to be funding this.

MS ABRAMSON: Although the other side of that, I guess, is the stakes are heavily involved in vocational education. So, it was - when we looked at it in the draft report, it's kind of a difficult question because both of the governments are heavily invested.

PROF KILLACKEY: Yes, it's difficult because it kind of fits in health and it kind of doesn't.

MS ABRAMSON: Yes. So, we made a choice, as you know. Really interested in what you said about the workforce. Because there's another part to it, of course. And, as you know, we've been concerned about workforce generally. And I'm sure you'll be making a further submission to us. So, on that particular Individual Placement Supports, any thoughts you have around what that workforce would look like? Whether we could draw on some peer workforce to provide some of that, would be very helpful.

PROF KILLACKEY: Yes. Well we've been - in one of our IPS set ups in some of headspaces in Melbourne have been using vocational peer support workers. And they work alongside the IPS worker.

MS ABRAMSON: Yes.

PROF KILLACKEY: And that's been absolutely fantastic for engagement of young people. You know, there's so much face validity when a young person is talking to another young person about the fact that this is actually possible, that you can manage your illness and work. It's been, I think, you know, I'm slightly biased. And we are evaluating it. So, hopefully, the outcomes will be as good as I think that they'll be. So, yes, there's all sorts of things. I guess, the other thing that we've been thinking about too on that front is having a, sort of, a much better career structure for people who work in these jobs. So that you might have some sort of fairly basic entry level, kind of, qualification to work in it.

But you actually could train up and become, you know, more senior in your roles, with more, you know, responsibility, but more trained up as well. Because, I think when you look at other

areas of employment support in Australia, there's quite a high churn of workers. And I think part of the problem that causes that is that there's actually not a career structure for people working in that business, so that, you know, they do it for a while and there's no greater challenge to move on to next, they go and do something else.

MS ABRAMSON: That's been incredibly helpful.

PROF KILLACKEY: Thank you.

MS ABRAMSON: Thank you very much.

PROF KILLACKEY: Thank you.

MS ABRAMSON: Could I please ask Ms Quilty from the New South Wales Council of Social Services. And if you would be kind enough to state your name and organisation for the record, and whether you'd like to make a short opening statement, thank you.

MS QUILTY: Thank you. My name's Joanna Quilty, I'm the CEO of the New South Wales Council of Social Service and I would like to make an opening statement.

So, thank you for the opportunity to appear before the commission and contribute to this very important enquiry into mental health. The New South Wales Council of Social Service is the peak body for the social and community services sector in New South Wales. We represent over 400 organisations who work with people and communities experiencing inequality and disadvantage. And our membership all too often sees the nexus between mental health and poverty and inequality in the community. They work with people every day who are missing out on support and opportunities because of what they can or can't afford, because of their cultural background, or because of where they live.

Our latest report, 'Mapping Economic Disadvantage in New South Wales,' which we've undertaken with the National Centre for Social and Economic Modelling, shows that in this state alone there are nearly 900,000 people who are living below the poverty line. And that rates of poverty are higher outside of Sydney in regional areas. This aligns with what we know about regional communities having poorer health outcomes. The sad reality is that social and economic disadvantage is very much associated with a range of adverse mental health outcomes. And this affects families and communities in every corner of Australia.

But too many Australians with a mental health issue are not able to access the appropriate supports when and where they need them. There's a significant missing middle of services for those in the community whose conditions are too complex for primary care, but who are not eligible for acute or specialist care. All too often we see that people's situations need to escalate to crisis level for them to be able to enter the system and receive any sort of care or attention. This places enormous stress on the individual, and their family and friends, as they become increasingly unwell. And for those who are able to access some kind of support, it is just so challenging to navigate the complex system - or, in fact, systems - that are involved that you almost need an army of support people to do so.

Enormous persistence, but in the end it can get down to sheer luck as to whether you get the support that you need at the right time. So, to put it simply, the system is broken. And it's not just the mental health system that we're talking about. The systems that are meant to support us all when times are tough fail us time and time again. The ongoing public hearings for the Senate enquiry into the adequacy of Newstart and related payments continue to demonstrate that people are not getting the right support to get back on their feet, and that the welfare system is fact entrenching them in disadvantage. And we think this is important to keep in mind when looking at how to improve mental health and wellbeing in the community.

NCOSS certainly urges the Productivity Commission to consider in its final report how the current income support system acts as a barrier to people meeting their basic needs, accessing care and opportunities, and how this impacts their mental health. NCOSS was very pleased to see the scope of this enquiry, including how sectors beyond health, such as social services and housing, can improve or impact mental health. We were also pleased to see strong recommendations in the draft report around improving mental health support in education and housing. The importance of providing and adequately funding a broad range of ancillary services outside the mental health system that keep people supported and connected in their communities can't be overstated.

This social architecture acts as a safety net for many who would otherwise fall through the gaps. And the social architecture includes locally based groups providing support, practical assistance, and a helping hand to those who have nowhere else to go. Services such as neighbourhood centres, tenants advice services, family support services, financial counsellors and community transport providers, who are critical to connecting people to healthcare, particularly in regional areas. We also need to recognise that the effectiveness of many of the Commission's draft recommendations is very much dependent on the health and community service sector's ability and resources to implement them.

Governments across Australia are increasingly transferring responsibility for service provision to the community sector, but without providing adequate indexation or growth funding. Services are seeing increased demand. And this is arising from a range of structural issues, such as lack of affordable housing, declining regional economies, slow wages growth. And yet services are expected to respond to this by stretching existing resources which are not sufficient to cover basic cost increases, let alone rising demand. Individualised funding models, such as those in the NDIS and aged care, are also increasing the complexity of the operating environment. Particularly, for small, locally based organisations.

And we're also seeing that such models are opening up gaps in the service system. As people are not able to access a care package, either because they don't qualify, the waiting time is considerable, or because they don't have the wherewithal to navigate the system. And, again, people are turning to local, more generalist community services, or to councils, because they have nowhere else to go. All these factors together present a real threat to community service's ability to respond and adapt to rising community need. This means that the social architecture that keeps people well, engaged in their communities and outside the formal mental health system is very much under pressure and at risk of crumbling, if it doesn't get some serious bolstering.

The Commission is doing vitally important work, and I urge them to consider these additional issues in the final report to address mental health in the community. We then need all levels of government to implement and appropriately resource the final recommendations. And this includes supporting the community sector adequately to continue to do its work. Too many Australians are being let down by a failing system and it is the responsibility of all levels of government to ensure it is fixed. Thank you.

MS ABRAMSON: Thank you, Ms Quilty. We have a few questions for you. I'm really interested in what you spoke about - community led initiatives and social infrastructure. And I'm thinking about how do we build some of those supports. Because it's not just about funding. So, I'm just interested in your views on that.

MS QUILTY: No, it isn't just about funding.

MS ABRAMSON: I know funding matters (indistinct).

MS QUILTY: Funding does matter. Or, at least, it doesn't have to be about additional funding. I think it very much about flexibility, about listening to communities, and about giving them control over how funding is spent. What is needed in their community and what might the solutions be. And I think we hear a lot about co-design and, you know, making sure that we are person-centred by working with the people on the ground with lived experience. But, I think how that plays out in reality is variable, and we're still probably very much at the learning stage. And I think that needs to be done - improved - significantly. I think we do need more regional planning structures and more opportunity for the different parts of government and the sector to come together and jointly plan for particular localities, given that localities are very different and their needs differ a lot. And, again, involving the community and listening to their voice is critical.

MS ABRAMSON: Thank you. One other thing I wanted to ask you was whether you had views about what we've said about mental health discharge. So, supports for people when, you know, we've said no discharge into homelessness. But, really interested in your views about how we can improve those services.

MS QUILTY: Absolutely. We are seeing increasingly people being exited from a mental health facility, or from prison, or from drug and alcohol rehabilitation and put into, often times, social or public housing but without adequate support around them, so that invariably they are – are greatly at risk of homelessness, and there just isn't that case coordination that's put in place, that's going to help those people get the support that they need. And I think it is a real gap. There used to be the Department of Community Services would provide that kind of case coordination for people that had complex needs, but as their focus has shifted more to children at risk of entering child protection and their resources are very much dedicated to that particular issue, it does seem that people that don't fit into their identified cohorts are missing out, and I think are really floundering in the system. Thank you.

PROF WHITEFORD: Thank you. So the question that I asked earlier; the issue of the psychosocial support network of services, which are – or, some parts are called nonclinical component of what's needed in the community is – you'll find, often, when we talk to different groups, they need different things by that term psychosocial support. Do you know of a – the

taxonomy that's used in, from your perspective, to describe the range of services which are provided by the agencies that, sort of, come under the umbrella that you provide, or you cover?

MS QUILTY: So, I guess the agents, or the organisations that are members of NCOSS are very diverse. They range in size from very small in, you know, quite rural and remote communities to bigger organisations that would have a head office in Sydney and multiple sites around the state, or even nationally, and they can be providing a whole variety of services from financial counselling, to family support, to domestic violence, to homelessness, to housing, neighbourhood centres, information and referral, disability advocacy organisations; our membership is very diverse.

I guess, when it comes to mental health, they're not necessarily mental health experts or specialists, but what they do is they have a role in building social inclusions, and that sense of connectedness and belonging. So they tend to be more generalist, I guess. A lot of them are, you know, whoever comes in off the street to a neighbourhood centre and is in need of some assistance or advice or support can usually either get it there or be referred to where they need to go. So it is about being accessible, it is about being locally based, and very much community focussed, and building up relationships with other local organisations, and just, you know, being part of that community.

So, very much for people that are socially isolated. I think a lot of the services provided by organisations who are members of NCOSS, they're very much about keeping those people connected, giving them a sense that they've got somewhere to turn to that, you know, they're not completely alone. So it is about, you know, helping – providing a bit of a safety net for those people, and we know there's more and more people in our communities that are at risk of social isolation and exclusion.

PROF WHITEFORD: So the funding that's provided to those organisations, is it generic social, you know, inclusion, generically defined, or is it for homelessness, for domestic violence, for - - -

MS QUILTY: It's very much targeted, and more and more it's about delivering very precise and clear outcomes. So, there's a move away from that more general, 'we're here to promote social inclusion, we're here to build community connectedness.'

PROF WHITEFORD: Right.

MS QUILTY: And more a focus on particular cohorts, you know, meeting targets and delivering outcomes. But I think they still, in amongst that, do as much as possible to be a part of the community and to build that connection and social inclusion, but it is becoming tougher, absolutely.

PROF WHITEFORD: Okay, thank you.

MS ABRAMSON: Just a related point, I guess, is that the Commission has had a lot to say about stigma, and I'm just wondering – I mean, we've suggested things like campaigns, et cetera, but just any views that you might have on how we can tackle the stigma would be really interesting.

MS QUILTY: Well, I think having those locally more universal services, who are able to be there for people experiencing isolation, or other, you know, anxiety or other mental health issues, they are non-stigmatising, because they are available for everyone. So, you know, whether it's a neighbourhood centre, a family support service, a play group; you can turn up, you can just be with other people who may be going through similar things, or who may not, and through building up trust and a relationship with others, then I think we can help to either provide necessary support or refer them to where they need to go. So I think it is a soft entry point, and it's non-stigmatising, and I think we need more of those.

MS ABRAMSON: Thank you. We welcome a submission, which I'm sure you'll make to us. Thank you very much.

MS QUILTY: Thank you for the opportunity.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Could I ask – now, another one I will pronounce it wrongly, I'm sure, Carsten Schley, from headspace Sunshine.

MR SCHLEY: That was actually very good.

MS ABRAMSON: Thank you. If you'd be kind enough to announce your name and organisation for the transcript, and invite you to make an opening statement, should you wish to do so.

MR SCHLEY: Thank you, will do. So, yeah, for the record, my name is Carsten Schley. I'm the clinical services manager for headspace Sunshine. So this is a headspace centre in the western area of metro-Melbourne. I have been there for the last ten years, seven of those as the centre manager. So, thank you very much for the opportunity to speak. I had a really good day already, and I hope that I can dovetail a few things, but mainly, really, what I submitted to you today is already encapsulating a lot of the remarks that predecessors have made today.

My main hold, really, is for my contribution, perhaps, to keep helping from the Commission's understanding of the current strength and potential of the challenges of the headspace centre platform, and obviously with true authority, I can only speak for my own centre, having been in the business for a bit more, I think there are quite a number of centres that have very similar experiences to mine. It's a wonderful report, I must say. I strongly agree with most of the recommendations you're making. I do want to raise a concern, however, I have, with regard to what could be a potential misunderstanding of the current and future strength and limitations of the headspace centres. Specifically, I'd like to talk about outcome measurements, and like my predecessor, I would like to talk about the missing middle, and the importance of being involved in our families, and others, and if I still have time, also, peer support.

So the Commission correctly quotes the published evaluations of the headspace centres that say that on the basis of numerical changes on the Kessler 10, the K10 that headspace services achieved small improvements in the mental health of headspace clients. However, you also mention in the report that a clinical falls alone on outcome often overlooks, you know, the

many deterrents that, you know, can effect wellbeing and mental health, and so certainly would like to see that be broadened, perhaps, the view of outcomes beyond single psychometric measure, particularly when it comes to including the experiences of young people and family, and important others themselves, and indeed there are some publications available on what they have to say about their experience of coming to us.

So, I would say that, you know, before we can draw firm conclusions about the things that headspace centres really do achieve, we might have to, as you recommend, have a more comprehensive and nationally consisting monitoring and reporting framework, because I don't think that outcome is currently really captured adequately in the way that, you know, we are asked to measure it. Having said that, there are, actually, right now, in each headspace centre around the country of which there are no 110, a number of other outcome measures available that are actually self-reported by young people, and families that are perhaps far more eloquent, I suppose, in what they are experiencing of coming to us, then, as I said, the numerical change on the K10.

With regard to the missing middle, you've clearly stated that the headspace initiative was initially created to provide low intensity interventions for people with mild and moderate mental health problems, and you have also stated that low intensity interventions with people with early problems can be highly effective, and indeed we can see this at my centre and at many other centres in the country. And as such, I absolutely support your call for headspace centres to have an even greater focus on low intensity interventions, and I think we're doing really well with that. However, if that is so, and if in fact the future funding of headspace centres should depend on, say, the amount of lower intensity services that we can provide, then you must include recommendations about where people can go when they need more than just invitation, low intensity intervention.

Just to illustrate what I mean, at my centre 60 per cent of the young folk that are now coming to us are now falling in the category of people with established and severe mental disorders, and there has been a real creep, and that's what you acknowledge with the missing middle over the years, from people who historically might have been, you know, presenting with early symptoms, but now, however, as I said, 60 per cent have ongoing severe problems, and the main reason that we are seeing them now is that our state system can't. So, people who have been turned away come to us, and because we have an open door policy, we see them, and we will make do, and with many we still achieve very reasonable outcomes, however most of our resources now are dedicated to looking after people who clearly demand a greater level of servicing than, say, someone who has just, you know, had a relationship break up, but otherwise they're okay.

So I absolutely, as a centre manager, would love to return to catching people, or problems, I suppose, early, and much earlier than we are currently able to do, and again I can't speak for any – every headspace centre in the country, but I do, you know, implore you to look at, you know, the variance of, you know, presentations that are coming to headspace centre, and clearly, if say for a centre like mine, and west of Melbourne, the ruling was that, you know, we would need to primarily support low intensity interventions and then to stay in government assistance need to be funded, accordingly, around so, so we can really, then, follow the staging model as you're proposing in the report.

Thirdly, I'd like to talk about the high importance of family inclusive practice, and we have heard some of that today, but a great deal. You, yourself, acknowledge that we do need to improve services to better meet the needs of families and carers, because we know, internationally, and nationally from research that outcomes are usually better if we do. Despite earlier recommendations and it's in the paper of (indistinct) that you offer, I have courted to increase the capacity of headspace centres to provide such family based treatments, actually no headspace centre in the country is currently providing any resourcing to do that kind of work.

What we do is that we are trying to partner, and in some ways are quite successful, with organisations in our community, and in fact that's one of the strength, I think, of the model, because we do have to partner, we do it quite well, but it isn't quite the same as having an integrated, you know, family peer support worker, for example, that is available, you know, most days of the week to provide the services to our family and friends that they really do need.

Just to give you an example, we have a complicated family peer support a half a day a fortnight, at the moment, at our centre, and as you can imagine, they are hopelessly overbooked. So again, I would just like to propose that you look at how can we boost, I suppose, the supports available to family and friends in our centres, you know, without necessarily having to rely on whether you can form partnerships in the community, because some area will not even have a child and youth and family service at their doorstep. They can provide that.

And then, maybe lastly, if I can, add that one as well, we have heard already throughout the day that obviously Australia is made up of many, many people from different ethnicities, and for languages, religious backgrounds, virtual beliefs and so on, and again there's a national platform for now 12 years we have been employed to work with people from non-English speaking backgrounds. My area, in Sunshine West and Melbourne has one of the highest (indistinct) densities in Victoria, and yet, I have absolutely no resource, at the moment, to help me speak the language of the people around us. So, as you will now, as a health provider, we have no national platform that currently funds translation and (indistinct) services our specialist doctors can, but that's obviously not enough when it comes to ongoing therapy.

And I can tell you, in the ten years that I've been at my centre now, there have only been two occasions where we have successfully managed to get an interpreter into the centre to provide ongoing therapy. We use it quite a bit of initial contact, but then, you know, we tell people about what headspace can do, in the language that they can understand, and then after that, you know, we basically lend them our bottoms, because actually there isn't a great deal more we can do. So again, just a recommendation, that if we want to be (indistinct) into the (indistinct) community, we need to be able to speak their language or understand them better. Thank you.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Thank you for that, sir. What a good coverage of many things. I've got some questions that come out of that. So, what's the relationship between your centre and the National headspace Centre, and is that – is it working, is it not working, how could it be better? Especially, I suppose, with respect to, you know, data collection and those sorts of things.

MR SCHLEY: Yes. As you know, the relationship between headspace National Office and the centres has undergone various strains over – over the years. Based on the most recent model, what headspace National is now really involved in, apart from providing services on the, you know, the headspace schools, and the headspace Initiative, is to be helping us to – with workforce development, training needs, also with, of course, the standards that every centre has to work towards certain standards, how they do it however is up to the centre itself. So when we go through the accreditation process that we are obliged to do so they can operate under the brand, we don't just say, or have to say, 'Yes we do some community awareness work,' we actually have to spell out how we do this in the community. So headspace National Offices is very heavily involved in that, together with the PHN.

All our data is still going to headspace National Office, and they share a portion of that with the PHN. We as centres see quite a bit of (indistinct) back, but usually have the data that I can't drill into to really help me understand specific outcomes. So again, one can measure it's not ideal - - -

PROF WHITEFORD: Sorry, how? So dated back to back, your centre about the number of headspace centres?

MR SCHLEY: Well, I do have - - -

PROF WHITEFORD: For benchmarking.

MR SCHLEY: I do get the benchmark, against the national average, if you will, so I know that my centre, for example, sees twice the national average on complexity. But again, that doesn't tell me enough, you know? It doesn't tell me what's that about, and what kind of interventions would be more likely or less likely to help me address the issue. I do believe that there are ongoing challenges in figuring out these, sort of, three parents that we now have. You know, we have the PHN, we have the lead agency, and we have headspace National Office. I'm not sure that I know what the answer is to, you know, how that would work best - - -

PROF WHITEFORD: Walk through those three for me, again. Your PHN?

MR SCHLEY: Yes, as the funding body. And there is, you know, the lead agency. In my case, actually, it's Orygen, and then the lead agency has a consortium around them, so they might be five, six, ten, fifteen, however local services that have once put up their hand and say, we would like to be involved in the running of a headspace centre. And then of course there is headspace National Office (indistinct) brand, and originally were entrusted with some responsibility of setting up and establishing headspace centres. That now falls more to the consortium and the PHN, but headspace National still holds the brands, so they are still coming in with, you know, more fidelity. So it's quite a complex little number. It's a bit like Jim's Mowing. Jim can't mow all the lawns in Australia, so they have to contract that out - - -

MS ABRAMSON: I thought it was him.

MR SCHLEY: There you go. So I'm glad I can shed some more light on how complex that really is. For me on the ground, it actually leads, often, to a bit of confusion, you know, who I'm now going to report to or work with. I mean, I know for governance matters it's clearly

the agency, but they don't really pay me, so then I have to work with the PHN around, you know, outcome report, and work plans, and then I have to – to meet the model fidelity criteria for headspace National Office. So I'm basically drowning in admin, if you get me.

PROF WHITEFORD: So, would you be able to make some suggestions to us that would make it easier for you to operate where we didn't have that complexity. I think from what you're saying, and from what other people have told us, there's multiple attempts to try and integrate headspace into the primary, you know, mental health services and community mental health services for a region, but again maintain the identity and fidelity of the model, and the funding comes through a different channel to where your, you know, national body is, et cetera. So, it's trying to do too many things, perhaps? I don't know, but we'd appreciate some way of trying to simplify that.

MR SCHLEY: Yes. Actually, what I'd like to do, maybe, is to divorce the question around governance and funding and reporting from what actually a headspace centre does on the ground, because I think what gets often forgotten is the main strength of the model, because, you know, my centre is one of four that is governed by Orygen, and these are all within a 25 kilometre radius. Although they're all operating under the same brand, and therefore have to be compliant, if you will, with the fidelity criteria. Even those four centres are quite different, they are always geared towards what does the community want. And I am not saying that we are the be-and-end-all of that now, because I think their community development will be fantastic to have part of any kind of service, but we don't. We still, kind of, we're having no youth reference groups and family reference groups. And we do ask, but I think to truly engage in community and co-design, we would have to do, you know, things quite differently.

So I don't think it's the centres on the ground to actually, you know, uphold the really good at what, you know, they're doing in terms of partnering with organisations, and not doing them all themselves, even though we're meant to be a one stop shop. But it's not the intent of a headspace centre to do their own thing. Actually, the model says you know, you need to partner, you need to be establishing yourself in the community. Where it gets a bit mucky sometimes is then who determines that goes in the community. So I might have a great idea, but the PHN might have another, and this is where we start to get, you know, into a bit of trouble. And if you have, then, two other parents who also might chip in some ideas.

So, can I give you an idea by what is the governance model would look like? Probably not at the moment. I can do a bit of thinking, but on the ground I can't tell. I just want to, you know, get across that it's not so much the centres on the ground that are part of the issue here, rather than how and where they report to, who actually makes the call on what they're doing in the community. Because a lot of them are being told, 'You need to do what your community wants,' but then we get initiatives, you know, to our doorstep and we have to, sort of, roll out, we think, 'I'm not sure that that's really what we need.' But, you know, it would be good for one region, but not for another.

So this is always where I thought, if the model was brilliant, actually to say, 'You do what is important in your community, whilst upholding standards, the evidence-base, and whatever.' But that becomes more, I think, more of a threat now that they don't call.

PROF WHITEFORD: So, just to put – sorry, one more question around that, and it extends that area. So, for example, there's a lot of promotion going along for more low intensity services, or increase access to internet based therapies, et cetera. How does your headspace respond to that? Like, do you think, you know, we sat down and thought about how we might fit that in, whether it's applicable for us in our local community, or how do you handle those, sort of, I guess, suggestions about where on the Stepped Care Model we should be, you know, referring our clients, our consumers.

MR SCHLEY: Well, again, I can only speak for my own centre, and I must say that we perhaps have been way ahead of our time there, because we used to deliver low intensity and online interventions eight years ago. We struggle to do that now, because of the change in, you know, the young people and that profile that comes to us, now, who are no longer perhaps just responding to low intensity. But what I can say, with regard to low intensity: seven years ago, when we noticed that we had more and more young people coming in who deserved more significant intervention, or care, or needed more care, we actually established in our centre, a different pathway which became a student run clinic, or the brief interventions clinic, which is exactly those kind of low intensity interventions that you're referring to.

When people went in there, those people with early problems, within three to six sessions, they, themselves, reported a significant increase in mental wellbeing, functioning, and what have you. That is absolutely without doubt, when we should intervene, and when we also need the littlest investment to have the greatest outcome. These days, I'm spending most of my time scaffolding around people who probably don't do that well on the headspace platform, who do probably need – or not probably – they do need a tertiary wraparound, team based, case management and integrated care, which is very hard to replicate for headspace centres, and then we get, sort of, Band-Aids, you know, like Eoin was talking about, that could use severe funding.

You know, a single person in a 1,200 kids that we get a year, it's a drop in the hot stone. It does not replace, you know, an integrated, team based, you know, state mental health service, and I've worked for many of those in my career, and those services too, and they are better for certain people. They're a better fit than (indistinct). And again, we have seen such a decrease of what our state services can see, or shall I say, not keeping up with (indistinct) and integrated, you know, outcomes, and generally that now our centre, or our centres, I suppose, you know, choke on, you know, needing to deal with, I guess, you know, complex issues that probably weren't meant to be addressed in the first place.

PROF WHITEFORD: Okay, that's – okay.

MR SCHLEY: But online (indistinct) providing to our centres, and works really well.

MS ABRAMSON: I might unjust ask you one question, then we'll break for afternoon tea. Do you look at the outcomes of individual practitioners? Because we had some evidence on Melbourne about the monitoring of outcomes for individuals - - -

MR SCHLEY: Yes.

MS ABRAMSON: You do?

MR SCHLEY: I do, on the basis of the very limited outcome measures that I have. I much prepare final audits, because I than don't miss the context, and the qualitative elements. If I just look at the (indistinct) then I think that's unfair to anybody, because, like, you know, with the brief in the lecture clinic works, we have clearly seen that once people might still have a high K10, they themselves all say functioning so much better, that's all I needed. So it's really, really vital that we ignore the review from just, you know, looking at psychometrics, and include, you know, the personal experience of people, because otherwise we will not measure change properly, I don't think.

MS ABRAMSON: Thank you. Thank you very much.

PROF WHITEFORD: Thank you very much.

MS ABRAMSON: We'll have a break now until 3.30. Thank you.

SHORT ADJOURNMENT

RESUMED

MS ABRAMSON: Thank you if we can reconvene the hearing. Excuse me, if we could reconvene the hearing. Thank you, and if I could please call Ms Pickett. If you would like to state your name and where you're from for the record and you might like to also make an opening statement.

MS PICKETT: Okay. So I'm Lynda Pickett. I'm the Australian Project Coordinator for Vicious Cycle PMDD. We're a global patient led project passionate about raising awareness of premenstrual dysphoric disorder and improving the standards of care for people living with this debilitating condition. Firstly, thank you for allowing me to address the commission and to represent the one in 20 women and individuals assigned female at birth of reproductive age who live with premenstrual dysphoric disorder. Historically we've been overlooked in conversations around mental health and we're grateful for this opportunity. We applaud the recommendations in the draft report, but we feel that unless there is a targeted action plan to address the complex needs of premenstrual dysphoric disorder patients, our community will continue to struggle.

Before I go any further I just wanted to address figure 1, which is who is mentally distressed and unwell.

MS ABRAMSON: In our draft report?

MS PICKETT: Yes. So we were surprised to see that it did not include differences in the experience of mental health between the sexes, male, female, non-binary and transgender in their experience of mental illness. We know that women are twice as likely as men to suffer from depression, three times as likely to be diagnosed with bipolar disorder, three times as

likely to attempt suicide during the reproductive years. It's also important to note that transgender men pre and post transition face additional challenges that influence symptoms of depression, anxiety, rage and suicidality as a result of hormone replacement therapy and/or continued ovarian cycles.

To oversight these gender disparities would be to ignore the impact of sex hormones on mental health and misrepresent those living with hormone based mood disorders such as myself. So premenstrual dysphoric disorder if you aren't aware is a cyclical hormone based mood disorder. It's a severe negative, cognitive and emotional response to normal hormone fluctuations. PMDD has been included in the diagnostic and statistical manual since the fifth edition in 2013. In 2017 the National Institute of Mental Health researchers discovered molecular mechanisms pointing to an abnormal cellular response to ovarian steroids as the root cause of PMDD, providing once and for all that the very marked irritability, depression, anxiety and dysfunction experienced by some women in the luteal phase was not just PMS or all in their heads and far from what some have argued in this country to be a social construct.

In May of this year the World Health Organisation added PMDD to the international statistical classification of diseases and related health problems in its eleventh revision, validating PMDD as a legitimate medical diagnosis worldwide. Despite this all - sorry, despite all of this PMDD is not currently part of any GP training. There are no training and development opportunities for GPs to upskill in this area. RACGP have no publications on PMDD. Australia does not currently have national treatment guidelines or an interdisciplinary consensus on the management of PMDD. When I questioned RANCP about why there were no detailed guidelines on PMDD in their document for mood disorders, I was told the document was already too long and in that moment my experience was reduced to a waste of paper.

So patients are now doing what they can with - from the bottom up, because we're not getting support from the top down in Australia. I'm privileged to have been given permission to share with you a few of the preliminary findings of the 2018 global survey of premenstrual disorders. This study was a collaboration between the international association of premenstrual disorders, Vicious Cycle and Me v PMDD, which is the world's first PMDD specific tracking app, and overseen by Dr Tory Eisenlohr-Moul, Assistant Professor of Psychiatry at the University of Illinois at Chicago, and IAPMD Clinical Advisory Board chair.

I must note that while complete findings are still pending scientific peer review and publication, preliminary data is available which reflects IAPMD's internal analyses. The full results will be published by the IAPMD Clinical Advisory Board in a peer review journal in 2019, as well as shared through a series of white papers. So these were our findings. In our sample of 1,425 patients with prospectively confirmed PMDD, 30 per cent reported that they had attempted suicide to escape their symptoms. In comparison the similar statistic for depression is 10 per cent. Patients are an average of 6.15 providers before receiving a diagnosis of a premenstrual disorder.

Patients waited an average of 12 years for an accurate diagnosis. The Australian specific statistic is eight years. 16.8 per cent reported having lost a job due to PMDD. 56.7 per cent reported having lost an intimate partner relationship due to PMDD. 98 per cent and 97 per cent feel PMDD puts a significant strain on their intimate partner relationship and family relationships respectively. 42.7 per cent reported problems with parenting due to PMDD, while

10.5 per cent felt completely unable to parent during PMDD. Early analyses of the study shows it is consistent with a history of studies, finding higher suicide attempt risk around the onset of menses, highlighting the need to take this issue seriously and conduct further research including experiments to understand how hormone changes contribute to this risk.

People living with PMDD have a number of additional challenges. We face misdiagnosis because our symptoms are so similar to bipolar disorder, rapid cycling bipolar, as well as generalised depression and anxiety. If at the GP level we're not asked to track our menstrual cycle against our moods, we're often misdiagnosed as those other disorders and then mistreated with inappropriate medications, and that hormonal element isn't taken into account and without that being treated the other treatments are ineffective and we just bounce around the system trialling medication after medication.

We're often dismissed at the GP level as simply having PMS. I would like to just have PMS. It's experienced by most people who menstruate. PMDD is specific to only 5 to 8 per cent of the population, and we're talking about a severity that renders them unable to work, study or maintain interpersonal relationships. We also face the taboo and the additional stigma that surrounds periods and talking about menstruation. There is currently no test, saliva, urine or blood test that can diagnose PMDD. So we are relying on doctors to ask for prospective symptom cycle tracking for at least two months. This is crucial to establish that essential hormone connection for correct diagnosis and treatment.

Then we have the fractured medical system between gynaecology and psychiatry and the lack of communication between the two. I've personally contacted all the big players myself, and they pass the buck. So RANZCOG points the finger at RACGP. RACGP points the responsibility back on RANZCOG, and I told you what the response was from the president of RANCP. The excuse is always given that more research is needed, but as I've outlined before the evidence is clear, the rest of the world is on board and it's time for Australia to step up.

We need a national action plan for PMDD, not dissimilar to one we've just seen executed for endometriosis. That up fills medical and mental health practitioners in diagnosis, treating and supporting PMDD patients, one which draws on advice from experts in the field. I will point out somebody who's doing exceptional work is Professor Jayashri Kulkarni from Monash, and Professor John Eden from the Women's Health Research Institute Australia as people to draw on as experts in the field.

It also needs to be one which utilises valuable patient consultation. At the moment, we are surviving in peer support groups online. That's all the support that we have. We have the IAPMD, who are doing exceptional work, and I urge anybody who wants to include premenstrual disorders in the work that they do in mental health to look at that website. There are resources for providers, for patients, for families. It's an excellent resource, we need to use it as a model for someone localised here in Australia.

Early intervention and education in communities and schools, and public awareness campaigns, along with support for patients, is sorely needed. But the good news is that all this can take place immediately within the current structure, and it has the potential to greatly improve mental health and social outcomes for the PMDD community. In the notes that I've submitted, I listed a whole range of ideas and - - -

MS ABRAMSON: We have those, thank you.

MS PICKETT: - - - and ways that I personally view, going forward, with an action plan for PMDD, if you'd like me to discuss any of those I can, but – yeah, I guess my main point here is that PMDD awareness is suicide prevention, and at the moment we are completely, just, being pushed under the bus.

MS ABRAMSON: Ms Pickett, thank you very much for coming to give evidence to us today. I don't imagine it's an easy thing to do, and you're speaking on behalf of a whole lot of people who wouldn't have a voice unless you came and spoke to us, so thank you for that. I'm going to ask my colleague, Professor Whiteford, to ask you some questions.

PROF WHITEFORD: So, thanks for taking us through that. It's obviously a challenge to, as you said, to try and capture an experience which has been hard for you personally, and certainly for people that you now know a lot of. We haven't, in the report as you rightly point out, gone into specific disorders in detail, and tried to provide a recommendation about, you know, clinical treatment, or services for specific disorders, and given that you can target specific disorders, as you said (indistinct) and endometriosis, but also require mainstream services to better accommodate disorders which are under recognised and under treated, you started to touch on how we might be able to get mainstream services to better recognise and provide support and treatment.

MS PICKETT: I think at that governing body level, once a new disorder comes into those documents, like the World Health Organisation listing, once new diagnoses arise, they need to become part of formal training. It doesn't matter if it's PMDD or something else. There needs to be a process where it becomes part of the curriculum.

UNIDENTIFIED SPEAKER: That's what I was saying.

PROF WHITEFORD: And from what you've learned so far, that is not happening with PMDD.

MS PICKETT: No, my doctor learned everything she knows about PMDD from me.

PROF WHITEFORD: And your doctor is a general practitioner?

MS PICKETT: Yes.

PROF WHITEFORD: And as far as Professor Kulkarni, you mentioned, who's a prominent Australia psychiatrist who's done a lot of research in the area, have you had a chance to speak to someone like her about what she believes could be done?

MS PICKETT: I believe she's working on a diagnostic tool. She's also on a women's mental health board, I believe. But I've just noticed in the way that she has been publically speaking about this, we did a television thing together, you know, just even starting the conversations. She's coming aboard, and she's speaking out, and the information that's she's giving is really

dispelling those myths, and the confusion between PMS and PMDD, and she's upskilling her colleagues, and I just commend her for that.

PROF WHITEFORD: So, do you take that as the start of a process, then, that needs to then continue and expand significantly, what she's doing?

MS PICKETT: Yeah. I don't know of any other professional doing what she's doing. Professor Eden has done some good work. But when I try to advocate for him to become more involved, it wasn't – it's not his area of speciality. He's a menopause guy. There's just no one to go to in Australia who's an authority on this.

PROF WHITEFORD: Okay.

MS PICKETT: I wrote to Ms (Indistinct) and asked for advice, and I was directed to Jean Hailes for women. I've given them feedback for years. They've made some small changes to their website, for example they've included a link to the IAMPD website, which is the one that I mentioned earlier; they've had a few articles in their magazine. But there's actually no practical support for us. I got them to link to the – the (indistinct) guidelines, which is what our GPs refer to, in the management of PMS. I've got them to link that to their website as well, but I just think there's so much more than can be done.

PROF WHITEFORD: All right. Thank you for that. I'm sure there is a lot more that can be done – but that, I think putting on the agenda here, is part of that process, I suppose.

MS ABRAMSON: And Ms Pickett, if I could encourage you – I'm sure you're doing all of this in a voluntary basis, but putting a submission into the Enquiry would mean that we have something in a form apart from the transcript that we can take into account.

MS PICKETT: Yes.

MS ABRAMSON: But thank you for coming forward.

MS PICKETT: No problem. Thank you.

MS ABRAMSON: Thank you. Could I please call, Jonathan Harms and Peta Smit-Colbran. And if you'd be kind enough to announce who you are, and where you're from, and make an opening statement if you wish to do so.

MR HARMS: Thanks. My name is Jonathan Harms, and I'm the CEO of Mental Health Carers NSW, which is the body recognised by the New South Wales health department for families and carers of people experiencing mental illness.

MS SMIT-COLBRAN: And my name is Peta Smit-Colbran, and I am a policy officer with Mental Health Carers NSW.

MR HARMS: And thank you very much for having us along today. Mental Health Carers NSW is very pleased with many of the recommendations of the draft product in the Commission report, including the suggestion to amend the test for carer payments, and relax

the hour test of on education for carers, to implement family-centred practice across the mental health system, and the carer experience survey, and have that data publically reported through the AIHW to allow practitioners to bill up to four family consultations through Medicare each year, and to correct the lack of data collection on mental health carers to inform decisions about carer services and funding.

However, we'd also like to highlight several issues of importance to carers in the sector, which could be broadly categorised under two headings, providing a safe, competent and effective mental health system, one that recognises the relational and bio-psychosocial model of mental health and recovery, and design services accordingly; and providing a system which recognises the unique and specific challenged experienced by families and carers, who provides and evaluates services that support their needs, to allow for their continuous improvement and expansion as required. On the detail of the specific carer support services, I'd like to go to Peta.

MS SMIT-COLBRAN: Yep, okay. So the Productivity Commission has rightly identified that although carer support services are valued, and are critical for family and carers, data collection on these services, and evaluation of these services is limited. I think that these should be addressed in the recommendations of the final report. For instance, you could add a recommendation that in the short term, while the ICSS is providing services for mental health services, data needs to be collected on the number of mental health carers who interact with the carer gateway, the number of mental health carers who receive services through the ICSS and the demographics, and the number of mental health carers who are eligible for the ICSS but are unable to access services.

MS ABRAMSON: Would you be kind enough to say what that acronym is for the purpose of the transcript.

MS SMIT-COLBRAN: It's the Integrated Carer Support Services. So that's the new services that will be delivered through the Commonwealth. Yes. And the number of mental health carers who are eligible for these services, but are unable to access them, if specialised services aren't available. In the medium term, government should agree on a set of outcome measurements for mental health carer services, which are publically reported through the AIHW. If the recommendation of the Productivity Commission to transfer mental health carer services to the state is agreed upon, then the arrangements which describe their responsibilities, should specifically mention data collection and evaluation of services. It's really important that this is included so that funding bodies actually have information to make decisions. At the moment, that's one of the specific reasons which is cited when decisions are made not to fund carer services.

So, I think the second item which we want to address is just recognising the relational aspects of mental health support and recovery, across all mental health services, and so do this we recommend a number of possible additional recommendations, such as expanding the mental health carer peer work force. This is really important, because carer peer workers can do what consumer care workers do for consumers in mental health, but for carers. There are very few specific carer peer work positions available, currently. Implementing definitive models for local health districts to implement family-centred practice, and mandating these. So, for instance, Mind Australia has published a practical guide for working with carers for people

with a mental illness, and in addition we acknowledge the recommendation that staff be hired who are dedicated to family with children in local health districts, but we think that this recommendation could be further to out additional staff who are just dedicated to working with family and carers this works well in the New South Wales context, with the family and mental health carer program that has driven quality improvement initiatives throughout the system, specifically related to family and carer engagement.

MR HARMS: Yes. It is very important, given the impact of those caring relationships on mental health and recovery, that we develop and support the caring environment that the person lives in from day to day, including addressing any obstacles that that environment might be creating to the recovery of their loved one, through ignorance of bad practice, just because they have never specifically been trained in being a mental health carer, as most people haven't.

That brings me to building a safe and competent mental health system. We are continuing to consider and refine the very detailed report that has been produced by the Productivity Commission and we're becoming more supportive of a number of aspects of the recommendations as we go on, but we still have some specific area that we'd like to see further developed.

MS ABRAMSON: Sure.

MR HARMS: So, with regards to the regional commissions centres that have been suggested, that would allow regional planning to take place between the relevant state and federal entities, for purchase of services on an ongoing basis. Regional commissions centres could be a way to achieve a consistent and collaborative approach in state and federal service planning, but we must take steps to prevent the perpetuation of silos between physical and mental health services. There are currently four projects being undertaken in New South Wales, at the moment, to address the physical health of people who experience mental illness, given the 20 year life expectancy gap between them and the general population, which is something which clearly needs to be taken very seriously.

We do fear that if all mental health services planning and commissioning is removed from the normal planning processes of health services, that that could create another barrier, but we're also aware of the fact that over – they calculate 50 per cent of Australians have a chronic health problem of one kind or another, and we don't support chronic health – physical health issues much more effectively than chronic mental health issues, and so if there should be a joint service plan of this kind between PHNs and state governments, or federal and state governments, then it should probably be rolled out to the chronic health and disability sector as well, and that would actually, probably, have a number of lateral benefits.

We say that new services must be co-designed with consumers and carers, if they're going to be effective. And importantly, the services must offer a range of options to fit highly individual and relational needs to support a person's recovery, because mental health is intensely personal. Instead of building specific steps for a Stepped Care Process, like stepping stones across a river of illness to the new country of recovery, there needs to be a causeway of stones which allow people to pick their own meandering way across. Because they will meander anyway, followed by their carers, and if the stones aren't there, they will simply fall in, instead of safely crossing to the far bank.

MS ABRAMSON: Don't be surprised if you see that in – but we give accreditation.

MR HARMS: Joint commissioning mechanisms could and should be contemplating by all kinds of chronic care, but I've addressed that previously, and new entities must ensure government commit to finding all the communities' needs, across the acuity continuum, rather than allowing (indistinct) to be perpetuated, or people to consistently fall out of care in an unplanned manner time and time again, with nothing being done to address the situation, in the comprehensive and competent fashion. The Productivity Commission should demand transparent reporting from governments, until (indistinct) has been decisively eliminated, and that brings me to the following point, around the information technology needs of the new scheme.

Information technology is required by responsible, responsive and competent mental health system. However, currently we do not have an IT system which would allow consumers to have one health plan which they develop, supported by their carers and clinical advisers, and which all service providers collaborating in delivering that care can see, understand their role in it, and also understand that multiple inputs are not going to create perverse or dangerous outcomes for the consumer, such as the mixing of medication, or the changing of medications, randomly, just because you've changed care settings, being admitted to hospital for example. That is intensely dangerous in the mental health system, and it is shocking that we don't have an information technology system that allows people to absolutely understand what is happening for a person in the community, when they're admitted through an ED to hospital.

Similarly, we do not have a system that would allow regional planners what all the different funded services and inputs government are putting forward and delivering in a particular region, in terms of the available services. This is vital, so that we can match what we are delivering up against the predictions of a national community mental health service planning framework, so that we can understand what should be provided, we can see what is effectively being provided by the state and federal, and to an extent local governments, and then we can match the delivered need or services against the need that is actually required by the community, and the just – the framework, the planning framework, as well as the funding for services to make sure that they are actually accessible by everybody who needs them.

Without that kind of model, which has been generated by a number of organisations, including the Sax Institute, and I believe that they even worked on the Mental Health Atlas have also done such modelling, then we are boxing in the dark and it is highly irresponsible not to be able to understand what changes you will achieve on the ground when you change different funded inputs. So there's an example used from western New South Wales where they wanted to implement two of the nine evidence based strategies to reduce suicide prevention, both of them would have stimulated demand for mental health services and so when they ran it through the model they found that that would increase suicidality because you hadn't already provided enhanced access to mental health services before you stimulated the demand.

So these are vital needs which a responsible system should fund and provide automatically to all public health service (indistinct). Mental health and other related support systems must recognise the role of relationships in supporting healthy development, the experience of mental wellbeing and recovery and support the role of carers in their loved one's life and treatment,

and the carer's own needs as individual citizens and potential clients of the same mental health system if they do not receive adequate mental health support. This of course includes carer breaks or carer respite, which must not be envisaged as a mere incident of support for consumers but should be a dedicated and co-designed support system specifically for mental health carers themselves, and we note that the funding that used to be provided to mental health carer respite has been in scope and allocated to the NDIS.

There is actually no clear way of consistently removing that funding and using it for carer benefit and so we would suggest that that whole system needs to be refunded for mental carers definitely, and probably for all the other carers as well. Thank you very much.

MS ABRAMSON: Thank you very much, that was a very eloquent presentation. I wanted to ask you a couple of issues which perhaps - and we've got the comments that you've made to us which we'll take on board.

MR HARMS: Thank you.

MS ABRAMSON: We had a really interesting and further participant's - quite a distressing story this morning about issues of consent, and that the people who gave evidence to us this morning really told us they were in a position that for an adult child they were unable to be involved in the care and their voice, to be honest, was actually neglected. The Commission is struggling with how to balance the rights of the individual, which for so long the sector has fought to have the consumer's voice heard, but we're trying to balance that with what could be done to give carer, genuine carer involvement, especially in circumstances where the person subject to the treatment is not in a position to give that consent. So I'm interested in your views.

MR HARMS: Well, look this is a problem that does arise quite frequently and it's not got a straight forward answer, but generally speaking the rules around confidentiality are important and it is important in respecting the autonomy and individuality of the consumer to respect their confidential information and not to give out holus-bolus to anyone who seems to be interested. However, just as carers can sometimes not be appropriate to be involved in someone's case because there's a history of abuse or some other issue like that, we can also say that consumers are not always totally committed to their own recovery or wellbeing when they are unwell.

And that creates a problem because if someone actually is determined not only not to look after themselves but maybe to actually actively harm themselves, it's important that information that allows the risk to be assessed and steps to be put in place to protect safety is available to the clinicians and the people that are going to act in that case. So we would - we've actually suggested to the New South Wales health department and we'd suggest again that a protocol around the sharing of information should be co-designed between clinicians, carers and consumers that clearly articulates that safety is the key and most important factor and that confidentiality should be observed as a rule but may be breached when safety is at issue.

And so we could develop a number of rules and mechanisms around how that could be done, but it should be done in a very open and transparent way with clearly articulated mechanisms and advice to all clinicians so it's done in the same way. New South Wales has had some very good success in a way with a designated and principal care providers - - -

MS ABRAMSON: Yes.

MR HARMS: - - - role recognised under the Mental Health Act which came on after the principal care provider, but even there we advocated for the creation of the principal care provider role which can be nominated by the treating team and not the consumer if they are unable or unwilling to do so, so that people who are providing care to someone in the community don't have that role ignored or destroyed because the consumer has said that they don't want any information to go to anyone under any circumstances when that is actually so that they can do things which are not consistent with their own safety.

MS ABRAMSON: We would be really interested in a written submission from you on that, it was - this morning it was really a very distressing circumstance that the people found themselves in so I would welcome that. Thank you.

MS SMIT-COLBRAN: I think just to add, often it's seen like as a conflict and I think it's a really common misconception that somehow family and carer engagement conflicts with the rights of the consumer to confidentiality et cetera, whereas in fact what we know is that many people when they're well state that they do want to have their family involved and even when people are unwell they will often want to have their family involved as supporters. Another point is that when we look at family engagement it's not about necessarily involving the family completely, it's about navigating ethically when - - -

MS ABRAMSON: Yes.

MS SMIT-COLBRAN: - - - to involve the family and how to respond to the family in a way that is supportive of what the consumer wants as well. So rather than look at it as something that contradicts itself, I think we should be looking at it as something that we do in tandem. Often when we exclude carers and family members, even when those carers and family members are problematic in the person's life it means that those issues go unaddressed. So it's far better to include them, to engage with them, to be supportive to them within the boundaries of confidentiality, and there are many ways for staff members to do that practically on the ground, and what we've found is that often practitioners lack education and understanding about how they can engage with family and carers productively, so they avoid doing that.

This has been noted through the Family and Carer Mental Health Program in New South Wales. So we have dedicated staff employed through the Family and Carer Mental Health Program within local health districts and those staff often engage with practitioners across the districts to improve their knowledge and to provide training around how they can be engaging with family and carers better and even they have found it to be the extent of knowledge around what people's responsibilities are under the Mental Health Act and under numerous policy directives which mention family and carer engagement. Often staff aren't aware of what those responsibilities look like and how they should be translated in practice.

So I think that knowledge building and training around these issues is really important across the system.

MS ABRAMSON: That's very helpful. Thank you. As I said I'd really welcome a submission on that. Thank you.

MR HARMS: I might just add one other point.

MS ABRAMSON: Of course.

MR HARMS: Which is because of the massive impact that a person's - the way a person is treated by others has on their personal identity and their experience of many aspects of recovery such as even hope for a better future, making sure that the informal carer supports are actually supporting recovery by developing them, providing family therapy if necessary, psychoeducation for sure, that's actually a crucial part of making an effective and cost efficient system, and so it shouldn't be seen as an option. We'd also note that the relationships that consumers have with their clinical advisers is equally important, and that's why the changing of mental health service culture to be non-stigmatising and to be warm and empathetic and supportive and so on is so crucial to eliminating seclusion and restraint, as well as to improving the outcomes achieved by those services.

MS ABRAMSON: Thank you, that's been very helpful and as I said I'd welcome a submission from you. Thank you.

MS SMIT-COLBRAN: Thank you.

MS ABRAMSON: Could I please call Mr Gye? If you'd be kind enough to state your - I'm sure everyone's heard it now - state your name and where you're from for the purposes of the transcript and invite you to make an opening statement, if you wish to do so. Thank you.

MR GYE: My name is Bill Gye. I'm the CEO of Community Mental Health Australia, and I want to begin by first of all thanking the Productivity Commission for this opportunity, and also as is proper to acknowledge country and the original custodians of this land and also to acknowledge anybody in the room with lived experience as well too, thank you for being here. Community Mental Health Australia is the national peak body for the eight state and territory community mental health and mental health peak bodies in each one of the states, and through them we represent 760 NGO organisations, assisting ballpark at the moment about 1000 people - 100,000 people with severe and persistent mental health issues.

My - I bring to this also too my own lived experience in having a mother who frequently went off to hospital with what they called a nervous breakdown in those days, and an overly friendly third class teacher, let me say, in a boys private school in Sydney and my own best friend's suicide at the age of 25 as well too, and as of last month 40 years' experience now in the community sector working in various different aspects. I obviously should begin by stating that there's been sufficient time to do a detailed analysis of this excellent 1238 pages including reference document, and that we will be submitting a more detailed written submission.

MS ABRAMSON: Thank you.

MR GYE: And at this stage the best that I can offer in the time we have is a tentative and general commentary on a couple of points.

MS ABRAMSON: Sure, understand.

MR GYE: Our original submission to the issues paper began with the statement that mental health is more than mental and more than a health issue. This makes it a complex matter as the subject matter refuses to stay within a single portfolio and requires outside the box thinking to really grapple with the psychosocial ecology of what we presently call mental health. The statement in the report that mental health services are tacked onto systems designed for physical illness speaks to this cross-portfolio reality.

The parable most applicable is probably the elephant and the blind man parable, if you are aware of it, where there's four blind men, it is a bit gender biased, who are exposed to an elephant for the first time and one is feeling the legs and one the tail, one the trunk, one the ears and one says, 'I know what an elephant is, it's like a tree', the one that's feeling the legs. 'I know what the elephant is, it's like a piece of rope', the one that's feeling the tail. 'No, no, you're all wrong' says the other, 'The elephant is actually like a giant palm leaf', the one that's feeling the ears, and the one that's feeling the trunk says, 'No, it's like a fire hose.'

And of course the reality is that they were all correct and it takes a long time to come to grips with the elephant and I'm sure you in your role here have heard many descriptions and important and impassioned pleas about various aspects (indistinct) and none of us can at this stage claim to know the full extent of it. So we've been (indistinct) in our perceptions based upon those experiences we've had in life to our understanding, and we neither can escape that bubble that we also exist in.

First of all, of course, congratulations for the document and for the wealth of information that it now allows us to mine and trail through in order to be able to reply with a hopefully cogent written response. But it's our initial view that at this stage the report has failed to come up with a new encompassing vision for mental health. As someone once said you can't - you don't invent the electric light by - the electric light bulb by continuous improvement on candles. The dilemma always is, of course, do I design a new house from a blank sheet of paper, from first principles, or does one have to work practically with the reality of the Lego pieces that are on the table before one.

This is not unlike the rebuild versus the renovate choice put in the report, but rather than applying that choice just to the issue of funding and governance it would be wonderful if we could articulate choices regarding the broader matter of the whole system design. We will comment more on this in our written submission, and what I will say here is that the three levels of: (1) primary mental i.e. shorthand for GPs, (2) secondary mental health, i.e. hospitals, and (3) tertiary mental health, i.e. specialists, are all founded on level zero, the ground zero of mental health which is community mental health, understood broadly as the mental health of the community for the community by the community.

It's the social and emotional wellbeing that our wise original owners of this land counsel us to consider as the embracing (indistinct) for those that are familiar with the approach that has been taken in many indigenous - many indigenous communities but also in the Australian indigenous community. In this framework we are social beings and our individual circumstances and conditions are largely though often invisibly the downstream effect of the wellbeing or

otherwise of the communities, including families that we live work and play in. It's a systemic approach to prevention and early intervention. This framework includes, but has more than the standard list of social determinates, housing, employment, et cetera.

As the (indistinct) of the recent - recently released New Zealand wellbeing budget, which I committed to you for inspection, had found there is not one portfolio that was not relevant and GDP in the New Zealand treasury policy document now is only a subset of their wellbeing index measuring national progress. If people have trouble grappling with this, and it is difficult, that's exactly the point and it's - and a situation where broad thinking is required and it's (indistinct) and does require some time until we converge critically down into what specifically is needed. So I apologise if some people might go: what the hells he talking about right now?

So I'll try and be a little bit specific. So as said there's been positives in the report, but I'll just focus on a couple of areas that we think is missing, incomplete or missing, or incorrect I should say. Missing, incomplete or incorrect. Firstly, unless we've missed it, the notion of trauma informed care is not mentioned in the report anywhere except in relation to ATSI services, Australian and Torres Strait Islander services there, and in that regard of course the current simple mantra of the field and a lot of consumers is don't ask what's wrong with me, ask what happened to me, and without that perspective we're missing an important chunk.

There's also no mention at all of non-traumatic at home crisis interventions, like open dialogue, though there are now three trials in Australia of that particular approach and that can come from either the community sector or it can come through a revision of the traditional asserted outreach approach there, but the benefit of it coming from the community sector is that there's a different relationship than there is between that and a health authority, and that seems to be a secret component of success rate in the evaluations of open dialogue. Mostly importantly though the need for a robust non-clinical recovery support workforce is not there, and by non-clinical I do not mean to put and us versus them implication there.

Indeed that traditional division between clinical and non-clinical is actually probably more unhelpful now than helpful there. There's many a service out there and run by an NGO service where there's CBT coaching and mindfulness training, as well everything else, social participation et cetera. So the boundary between what is traditionally thought of as clinical and non-clinical now are very broad, and so to that extent it may be best to think in terms of what's required necessarily and - rather than just what sector delivers it. But as I was saying though, what's an important omission in here is that there's no addressing in the work - the chapter on workforce development and elsewhere on the workforce employed particularly by the NGO sector working in the recovery support area there.

Using the figures - or there is a brief mention, I should say, of low intensity therapy coaches, so the peer workforce of course is including in there but not the other. In the PC document itself, it does state that in 2017 there were approximately 27,000 working - people working for the community managed organisations in the psycho-social service area. Our view was that it probably should be closer to about 30,000. By comparison, in 2017, there was 3,369 psychiatrists. Again, not that it's an 'us and them,' but to just give you a sense of scale and difference there.

As I'll mention in a moment, the community sector has been through its own traumatic transition in the (indistinct), which was quite damaging, and it was an example of poor change management, and we have lost a significant degree of intellectual capital, and that's a shame, because it had grown very well over the last 15 years, and a lot of taxpayers' dollars went into that, and I think, as I will mention, it was probably based on some overly-rosy assumptions on the transition rate that people go into the NDIS. And because of that, we – a number of people have left the sector, there's been restructures there, and probably somewhere in the order of 15 – 10,000 to 15,000 people with several mental illness have disappeared back into the woodwork which took a long to contact them, which is a very shame.

Now, the work force is – this work force is very important, and their ongoing skill development is vital to a future society with improved national wellbeing, and particularly for those disadvantaged. And the work force needs can be worked back from three principles: (1), if you clarify the outcomes needed specifically for economic and social participation, and maybe even a measure of self-effort (indistinct) measures, that will in turn define the competencies that you need for those outcomes, both inside and outside the NDIS, as this is also a matter for inside the NDIS as well, too, and that we don't want to just maintain people through care. We want to teach people to fish, rather than given them a fish, and that's an important difference between a lot of people's understanding of what people, either with disability or mental health, need, versus for those that have lived and worked in that area know what is actually required.

That's not to say that we – that the work force has those competencies now. Some do, but it needs to be articulated and then developed, because that will be the way we get those outcomes, and a component for that, of course, is the remuneration needs to be such that we can attract and maintain people with those competencies, and the transition to the NDIS has been another great blow to that, in that the average level of work in a lot of the NGOs has now had to go down from 3.8 down to 1.2, that's between 1 and 2, because organisations have had to shift their financial risk of going broke from their own bottom lines to staff. The casual work force has doubled, as well, too, as the able insight report recently showed, as well, too.

There was a mistake in chapter 12, this is a small point, in relation to the transition to the transition of the three previous commonwealth funded programs, that was partners in recovery, personal (indistinct) and support with day to day living in the community, and also that was the carer – the (indistinct) program that was also cut at the same time as well, too. What's said in the report there in one place – in one place it's correct, in another place it's not correct. I can give you the page reference there. It says that organisations providing those programs were funded to continue them – to continue those programs for another 12 months. That wasn't correct; money went to the PHNs, for the extent for each transition - - -

MS ABRAMSON: Sure.

MR GYE: - - - and not all organisations that were providing those were the lucky recipients of that funding, so it was a lot more messy than that. Some PHNs gave little, three-month funding to person by person, others were a bit more generous. So it's just a small error that I noted.

And lastly, the following issue is described, but a clear solution is not offered. It's probably my closing point, and arguably the most important point, really. It's a quote from the document itself, from one of the pages, amongst the 1,238 pages in there:

'Approximately 690,000 people have a severe mental illness. Approximately 64,000 of these are expected to be eligible for psycho-social support under the NDIS. While some of the others currently do and will receive psycho-supports, psycho reports find its review that the Australian state or territory Commonwealth governments, we estimate about 100,000 reinvestments. There remains a massive gap between the assessed needs and the services provided.'

So, 690,000, 64,000 which is 8 per cent of that of the NDIS, make it as best 100,00 currently getting services, and no clear – no clear plan for what we do, for what's now sometimes called the missing middle, and I'm sure you've probably heard that. But clearly, it's our big challenge, and one that governments will (indistinct) on, because I can't see any other way around it but extra funding, and a threat to surplus, but maybe in a longer term we should at least move towards it, and it should always be articulated, because the – while the political reality will be that we have limited funds, the long-term practical reality is that we must invest in prevention and early intervention.

And of course, this funding competes with emergency services and beds, which are always on the front page, and in an ideal world, of course you would do both, but I can't see – I still see that the practical reality is these will compete with each other. So my view is that whatever is recommended will be filtered by political compromise, so I would hope that the Productivity Commission in their prudence can push it forward hard on this long-term investment approach to prevention and early intervention, but of course the governments will work backwards and compromise everything from that point onwards. Thank you.

MS ABRAMSON: Thank you, Mr Gye. I just have our apologies that we've got one of the programs not quite right. It's more because we do things at that big level, but there are obviously regional variations. One of our difficulties with the community mental health workforce is that's it a really broad category, and we struggle to pick up the variety of job names, there was little consistent or comprehensive data on how many people are doing what, and what the measures of outcomes were for consumers. So we're really asking the sector to give us a bit of help with this.

MR GYE: Could do. Now, the great tragedy there was that in – a lot of work was done over the last 10 years to produce what was the NGO minimum data sets, the MDS. And it was ready to go, and what it would have given you, through the Australian Institute of Health and (indistinct) all those particular numbers. Now, you may or may not know that it got up in Western Australia, for awful design by strategic data in Melbourne, and it's still being used by the Commission in Western Australia. It partly got up in Queensland, there, but it then faltered and remained in the in-try of every other one of the states, and the Australian Institute of Health and Welfare, their protocols require at least a minimum of three states to submit their data, before the data is put up on their national reporting. They've asked for quite a while, 'Could we just have one more state?'

So because of that, our sector's invisible, it's been invisible, and that was also one of the explanations why, I think, the transition from those commonwealth programs that I've talked about was done as well, because people didn't know – perhaps didn't have clear idea of the signs. I won't be critical of the Departments, because I know they each have their stories and some of those people are my friends, so I won't be too hard on them in their absence, but I still say, I think there was a failure to collect the data and report it, and in fact there is a sad stories of failures that resulted in that, and certainly the sector itself could and should try to do that, but it really should have been part of the contractual requirements, over many years, to give the – give the decision makers, particularly the principle committee, those numbers, so that they could steer properly, and knew also of the downstream – you know, the effect downstream of that data not being there.

So the best we – we can make some guesstimates, at the moment, right now, but I can see that when you would have been collecting, you looked for hard data from the usual resources are not there.

MS ABRAMSON: Yes, absolutely.

MR GYE: But it's still, it's there, and happy – well, we will do our best.

MS ABRAMSON: (Indistinct).

MR GYE: (Indistinct) as best we can. There's a bit of a flip to move towards that NDIS data, to miss the – one of those torturous acronym sub-departments to the principle committee there, the one to do with an information strategic planning, so there's something afoot to make that happen. But yes, no, it is our greater issue. We've been invisible, and are invisible, and it's a real shame, because I think, particularly in regard to those three programs, and I will sound like I'm repeating myself, in my view, and in my years of experience, those three or four programs were one of the best created mental health programs that we've invented in this country over many, many years, and they work really well for consumers, carers, and it's a shame – what one should do when stepping across a slippery stream is not take your weight off the rock you're on before you've got your weight firmly on the next rock, and we hopped rock thinking that it was going to be there, and it turned out to be slippery or wobbly, and as you three will probably know, only 25 per cent at this point in time have been in those programs, which was at one stage 50,000 people, have ended up in the NDIS at this point in time, they're still swimming towards it.

MS ABRAMSON: Thank you. I've just got one more question, Mr Gye. I wanted to ask you about carer respite services. We're quite interested in this area, but we'd like to know what type of services, how should they be targeted, and of course the funding. Happy for you to take it on notice, if it's something you want to think about.

MR GYE: I will. I'll just speak off the cuff on a couple of remarks, and also pick up on the presentation that was done before, which was great. Certainly, it's in alignment with the broad comments I was making before about not having the focus exclusively on the individual, and what's happened to them, but putting them in a social context, and putting families in a context of communities. We have atomised it to nuclear families, but in those areas and those

communities that still keep extended families or other networks of community, there's a – there's a context in which families are apart, and not just a nuclear component of their own.

More specifically, I think the involvement of carers is essential and complex, because each situation is actually different, and often you've got people with inter-generational issues there, which is – which have maybe been undiagnosed, on the one hand. On the other hand, you've got people who have worked their entire life, doing extraordinary service there, and worrying what they're going to do when they pass on, the people who you were looking after.

As was mentioned before, in psycho-education, and where necessary family therapy are also a great adjunct, as well, to that. But respite, you know, respite services are still very important, and we tended to – we were moving towards that, and we tended to brush that way. That can work very well in the NIDS. If you're lucky enough to be a NDIS practitioner, that can be – that can actually work. When you asked – this might be interesting – when you ask carers what's the number one thing they do for respite, it's actually to improve the recovery and independence of their care recipient, of course, though it is still nice to have some opportunity for some (indistinct) to take over, just to give you a rest for a couple of days, I think is important.

So respite, psycho-education, family therapy, engagement of carers in the process, if you can get around those tricky confidentiality issues, and I agree, too, the open dialogue method I mentioned, as well, too, is more general for families. It's a very traumatic experience for a family to have the police or something come on in, and sometimes literally drag your care recipient out, and the damage that does both to the person and the other person, is ginormous to me. I have genetic trauma from that, and it's extraordinary. So I do commend open dialogue, and/or if we had the funding, we did have in Australia a wonderful (indistinct) outreach component in several areas of Australia, but Northern Sydney, actually, was one of the – was at one time regarded as one of the best in the world, and it's been a terribly downhill step by step, funding by funding, position by position not being filled, money going to the big machine that goes 'ping' and we're cancelled (indistinct) and those little behind the scenes hospital decisions.

So we've had it. And we could recreate it again, but we get back now to the governance and the funding issue that's so important, because we need to provide some assurity that when you put something together, we're not going to go through what I'm essentially saying. We've been there, and done that, and we're happy to impart (indistinct) wheels of things that have gone well, but the wheels have fallen on.

MS ABRAMSON: Thank you, Mr Gye. Thank you so much.

MR GYE: Thank you.

MS ABRAMSON: Can I just ask, before – I understand we have one person that wants to talk to us, in camera? Is that right, Henry? Before I do that, could I just if there's anyone from the floor that would like to have an opportunity to speak with us? Doesn't look like it. Could I thank people for their participation. Can I particularly thank people with lived experience who have come forward, and I understand it would not be easy to do so, and that's been most welcomed by the Commission. The Commission is now going to sit in camera, so if I could

ask everybody to leave the room, we'll take a short recess for five minutes or so, and then we'll come back in. Thank you.

**MATTER ADJOURNED UNTIL
TUESDAY, 26 NOVEMBER 2019**



Australian Government

Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

PROF STEPHEN KING, COMMISSIONER

MS JULIE ABRAMSON, COMMISSIONER

PROF HARVEY WHITEFORD, ASSOCIATE COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

**WESLEY CONFERENCE CENTRE, 220 PITT STREET, SYDNEY
ON TUESDAY 26 NOVEMBER 2019**

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PROF KING: Good morning. Welcome to the public hearings of the Productivity Commission inquiry into mental health. My name is Stephen King and I'm the presiding Commissioner on this inquiry. My fellow Commissioners are Julie Abramson, who has moved along way, away from me and - - -

MS ABRAMSON: It's to deal with the table legs, Stephen, it's not personal.

PROF KING: And I use Palmolive Gold, so. And Harvey Whiteford. Sorry, you need to be old enough to have seen a certain ad on television back in the seventies to - - -

MS ABRAMSON: It's now on the transcript, so.

PROF KING: I'd like to begin by acknowledging the traditional owners of the land on which we meet today, the Gadigal of the Eora Nation. I would like to pay my respects to Elders past, present and emerging. The inquiry started with reference from the Australian government in November 2018 and the purpose of this inquiry is to investigate the mental health system in Australia and make recommendations to government about how we can improve that system. We have talked to representatives of the Australia State and Territory government service providers and their peak bodies, unions, academics, researches and individuals with an interest in the issues and held round-tables throughout the inquiry.

We released an issues paper in January this year and have talked to the range of organisations and individuals. We have received 573 submissions since our issues paper came out. We are grateful to all the organisations in individuals who have taken the time to prepare submissions and/or appear at these hearings. A few weeks ago we published our draft report and purpose of these hearings is to provide an opportunity for interested parties to comment and provide feedback on the draft report to facilitate public scrutiny of the Commission's work and to get feedback on the draft report.

Now, we like to conduct all hearings in a reasonably informal manner, but I would like to remind participants that a full transcript is being taken and for that reason comments from the floor cannot be taken however at the end of day's proceedings I will provide an opportunity for anyone who wishes to do so to make a brief presentation. If anyone does wish to make a brief presentation please just let yourselves known to Henry and Ros, the two staff members at the back there.

This is the seventh public hearing for this inquiry following this hearing. Hearings will also be held in Broken Hill, Rockhampton, Brisbane, Launceston and Adelaide. We will then be working towards completing a final report having considered all the evidence presented at the hearings and in submissions as well as other formal discussions. For those planning to lodge a public submission with their feedback on the inquiry draft report eh closing date for submission is 23 January of next year.

The final report will be submitted to the Australian government in May. Participants and those who have registered their interest in the inquiry will be automatically advised of the final reports released by government which may be up to 25 parliamentary sitting days after completion which I think means August because someone had actually worked it out last night which was very impressive.

Participants are not required to take an oath but are required under the Productivity Commission Act to be truthful in their remarks. Participants are welcome to comment on the issues raised in other submissions. These proceedings will be livestreamed to the Commission's YouTube page. All participants who have registered here at this hearing have confirmed their understanding that they may be visible or audible online. If anyone has queries about this or does not wish to be visible or audible online please approach one of our inquiry team members here today or free feel to leave the hearing now.

The transcript will be made available to participants and will be available from the Commission's website within a week of this hearing. Submissions are also available on the website. If there's any media representatives attending today there are some general rules. Please see one of our staff members for a handout to explain the rules. Participants should also be aware that any media representatives present may be using Twitter and other internet mechanisms to convey information online in real time including participant's remarks and I note there are a few other people tweeting as well so for someone who's not on Twitter, go for it.

MS ABRAMSON: In 140 characters.

PROF KING: In 140 characters, that's true. To comply with the requirements of the Commonwealth Occupational Health & Safety Regulation you are advised that in the unlikely event of an emergency requiring evacuation of this building, there are exits there and there are exits out the way you came in and the assembly point is St James - no in Hyde Park near St James Cathedral. You can tell I'm not a local, I almost got them backwards.

In your opening remarks if you can try and keep them to no more than five minutes. We do have a fairly packed agenda today and then would like to follow up with question on your remarks. If at any time you are feeling distressed we have psychological support on hand so - Leanne, there at the front. And if there's any additional information that you'd like to convey we have team members here who are happy to talk to you.

So let me start today by asking Emma Spinks if you could join us down the front. If you would be able to say your name, if you are representing an organisation what the organisation is and any opening remarks for the transcript. So the two sets of mikes means that these ones are for amplification and the other ones are just for the transcript.

MS SPINKS: All right. Am I in the right spot here?

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

MS SPINKS: Okay. My name is Emma Spinks. I'm not in line with any organisation. I'm addressing the Commission, thank you for the opportunity. As a mother, just a mother, I'd like to give a personal account of my family's experience of problems within the mental health system which I believe have contributed to the death of my daughter.

My daughter was a loving and caring wife and mother, she had many friends. She had no history of consultations for anxiety or depression. Before her death she had been very sick for

over a month suffering from nausea, recurrent diarrhoea, chronic fatigue, significant weight loss and difficult sleeping. Pathology tests identified the case as hyperthyroidism and iron overload. An ultrasound of her thyroid gland had been ordered but was not carried out due to a pre-arranged family holiday which had to be cut short because of her illness.

On her return she visited the same medical practice because she was still feeling unwell and another general practitioner gave her a completely different diagnosis telling her that the chemical imbalance in her brain was causing her problems and anxiety. He prescribes Zoloft, and SSRI antidepressant which he said would rebalance her system but would take two weeks to work. He made no mention of side effects instead telling her that this drug was 'as safe as houses'.

Dr Peter R Breggin is a Harvard trained psychiatrist and former consultant to the National Institute of Mental Health. He has been a legal consultant for over 170 cases in the USA and has had extensive access to drug company clinical trials and data. In his YouTube videos he reports that the chemical imbalance in the brain theory was initially proposed by drug manufacturer Eli Lilly. It has since been used by other drug companies for marketing purposes. Dr Breggin states there is still no medical evidence that is able to prove any chemical imbalance (indistinct words) anyone who's not taken psychotropic drugs.

He advises that selective serotonin reuptake inhibitor antidepressants work by preventing the brain's reuptake of serotonin and making it (indistinct words) between neurons. This is supposed to create more serotonin but Dr Breggin warns there is much evidence to suggest that the brain doesn't like this and responds by 'lessening' the production of serotonin and becoming less sensitive to it. He also warns it can be extremely dangerous to suddenly stop taking these drugs without medical advice and supervision. The GPs use of the chemical imbalance theory as a diagnostic tool appears to be in direct conflict with the Royal Australian New Zealand College of Psychiatrists' clinical guide for the treatment of mood disorders.

On p.20 it states:

Understanding and piecing together the various factors provides a more comprehensive picture of why the individual has developed the mood disorder in the first place. It also acts as a forerunner to considering which interventions are most likely to be of benefit. In addition to understanding the individual, their strengths, vulnerabilities and their predicament, it is important to bear in mind that there may be alternative explanations and that different psychiatric diagnoses and general medical causes may ultimately be responsible. Psychiatric assessment should involve a medical examination and investigations as indicated. These tests need to be conducted on a case-by-case basis and tailored to individual needs

As the RANZCP state, 'general medical causes may ultimately be responsible' and in my daughter's case pathology tests ordered by another GP at the same medical practice two weeks earlier had been able to confirm that my daughter was suffering from hypothyroidism which has been medically proven to cause anxiety and iron storage disorders. Both the GP and the pharmacist who dispensed her prescription failed to warn my daughter about the risks associated with Zoloft, the possible side effects that include suicidal ideation and self-harm.

The Food and Drug Administration of the United States of America states on their website that:

'All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behaviour, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. The following symptoms, anxiety, agitation, hostility, aggressiveness, impulsivity, akathisia, hypomania, and mania, have been reported in reported with patients being treated with antidepressants

The FDA also notes that:

Families and caregivers of patients should be advised to look for the emergence of such symptoms on a day-to-day basis, since changes may be abrupt

The Food and Drug Administration of the USA have also forced manufacturers of SSRI antidepressants to place a black box warning, their highest level inside the packets of these drugs, for at least ten years. The governments, Canada (indistinct) European countries also require warnings to be placed in SSRI antidepressant drug packaging. In Australia the Therapeutic Goods Administration has no such requirement describing practitioners are instructed to warn patients and dispensing pharmacists who are supposed to provide a product information sheet with prescriptions.

In my daughter's case both these safety measures failed. As family we had absolutely no idea there was a prescription drug that could cause possible side effects of suicidal ideation and self-harm in anyone who hadn't even suffered from a mental illness. If a warning had been included in the packaging we would have been able to save my daughter's life. I know that if my daughter had been warned of the slightest risk of possible side effects of suicidal ideation and self-harm she would never even contemplate taking Zoloft.

I believe that the fact she received no warnings constitutes an extreme violation of her basic human Rights. No mental health care plan was provided for my daughter. The website of the International Union of Basic and Clinical Pharmacology advises that practitioners can 'never' be certain that a drug will be effective or safe for an individual patient so they must recognise the need to monitor the outcome of their prescription. They define an adverse drug reaction as actual harm that occurs to a patient when they are taking a drug. When psychotropic drugs are prescribed a mental health care plan is absolutely essential because of the possibility of adverse drug reactions such as akathisia.

In his YouTube videos Dr Breggin reports DSM-4 states that akathisia leads to suicidal ideation and self-harm. A mental health care plan would include: giving patients information about how to take their medication as safely as possible and especially warning them not to suddenly stop taking it without medical advice and supervision; making sure patients tell their carers to monitor them closely for any changes in mood or behaviour, suicidality or worsening of their anxiety and depression especially in the initial few months of therapy or around dose changes either increases or decreases; a follow-up phone call by the practitioner to check the patient's mood for any signs of the development of adverse drug reactions such as akathisia.

Dr David Healy, an internationally respected psychiatrist, psychopharmacologist and scientist reports on the RxISK website that significant symptoms of akathisia occur in around 20 per cent of people taking an antidepressant and at least 50 per cent of people on low doses of an antipsychotic. He also states healthy volunteers as well as patients are at risk and that a healthy volunteer trial of Zoloft in 1983 had to be abandoned before the end of the first week due to 'every' participant displaying signs of akathisia.

Symptoms of akathisia provided on RxISK's website by Dr David Healy are: anxiety or agitation, restlessness, feeling emotionally uneasy; dysphoria (feeling bad or depressed), difficulty sleeping; distress or panic attacks; difficulty sitting still; feeling the need to keep moving - for example, pacing back and forth; the feeling of wanting to jump out of your skin; dark and unpleasant thoughts; intense emotional turmoil and mental restlessness; strange and unusual impulses often of an aggressive nature; suicidality and homicidality. Sufferers often find it very difficult to explain exactly what is wrong even though they may be in unbearable distress.

The following account is taken from my daughter's husband's report to the police after her death. It describes the onset of akathisia symptoms and demonstrates that because they were not warned they were unable to recognise them. She took her first tablet on Saturday morning. After taking it she felt nauseous, quite anxious and uneasy to which she was surprised as she wasn't told about side effects.

Later that evening she called the chemist that she got the medication from to ask them if she would be able to take the tablets at night hoping that the side effects would be only while she slept and she was told, 'Yes, that would not be a problem'. That night she took the tablet before bed and it kept her awake and made her feel jittery all night. I noticed that the tablets made her withdrawn and not herself as she was always so bright and bubbly and always wanting to be with and play with the children but she was feeling uneasy and unable to do so.

On Monday we were discussing the effects of the medication and she was telling me that she did not like it and the way it made her feel. As we didn't know much about it and didn't know how severe the medication was we decided that as she didn't like taking it and it was making her feel worse then she should just 'stop' taking it.

On Tuesday morning my daughter drove her car to the top of the local multistorey shopping centre car park and fell to her death. Her poor body was so broken we were never allowed to see her again. The note that she left said she could not stand this pain any longer. On the RxISK's website Dr David Healy reports that David Foster Wallace who was suffering from symptoms of akathisia before his death was quoted as saying:

The person in whom its invisible agony reaches an unendurable level will kill herself the same way a trapped person will jump from the window of a burning high rise. The terror of falling from a great height is still just as great. It's not desiring the fall, it's the terror of the flames. You have to personally have been trapped and feel flames to understand the terror beyond falling

I complained to the New South Wales Health Care Complaints Commission that the GP appeared not to have followed the guidelines to justify the Royal Australian New Zealand College of Psychiatrists in making his diagnosis and he hasn't given due consideration to the physical causes of my daughter's anxiety that were identified by her pathology tests. They dismissed my complaint because they stated, 'There were features of depression'. Their only recommendation was that the GP should have described Valium together with Zoloft for the first one to two weeks to mitigate the known early side effects of worsening anxiety associated with this category of antidepressants.

The NSW HCCC appear to be unaware that increasing anxiety 'may' indicate the onset of an adverse drug reaction such as akathisia. On their website drugs.com advises that Valium has possible side effects that include anxiety, agitation, aggressiveness, irritability, hallucinations, psychosis and insomnia. When I phoned the Health Care Complaint Commission the officer handling my complaint told me that they currently had a number of cases that were similar to my daughter's and that she felt antidepressants were prescribed far too often.

A coronial inquest was held to examine the circumstances surrounding my daughter's death. No family members were invited to attend. The expert witness statement provided to the coroner by the GP reported that my daughter presented with an irritating cough, anxiety for months, depressed mood, (indistinct words) and not excited by things anymore. He also stated she was specifically asked of any suicidal feeling and that she clearly denied this. The exclusion of family members from the coronial inquest meant that no evidence was provided to the coroner about the fact that my daughter had been very sick for over a month before she died suffering from nausea, recurrent diarrhoea, significant weight loss, chronic fatigue and difficulty sleeping and that pathology tests had found her to be suffering from hyperthyroidism and iron overload. So the coroner's report gave the cause of death as 'The injuries she suffered from the fall and depression'.

I have read that a screening process is currently being conducted for all New South Wales primary school children to check for early signs of a mental illness. I am extremely concerned about the growing number of children who have been described SSRI antidepressants as Dr Peter Breggin warns on his YouTube videos that young children and adults under 24 are at an increased risk of side effects that include suicidal ideation and self-harm. He also warns that prescribing psychotropic drugs, including SSRI antidepressants for children, make expose their developing brains to the risk of permanent damage.

In conclusion I believe the main problems that contributed to my daughter's death were: (1) my daughter received no warning about the possible risks of side effects of the SSRI antidepressants which include suicidal ideation and self-harm; (2) despite the fact that the regulatory agencies in the USA, Canada, Britain European countries have forced manufacturers to provide a warning in the packet for over ten years the Therapeutic Goods Administration still does not require manufacturers to provide this additional safe measure for Australian citizens; (3) the use of drug company promotional material is a diagnostic tool rather than the clinical guidelines for the treatment of mood disorders provided by the Royal Australia and New Zealand College of Psychiatrists; (4) no mental health care plan was provided for my daughter to ensure that she was informed how to take her medication as safely as possible and was monitored appropriately to check for the onset of possible adverse drug reactions including akathisia, suicidal ideation and self-harm; the general practitioner, the

dispensing pharmacist and the New South Wales Health Care Complaints Commission appear to show a general lack of awareness and knowledge regarding the risk and symptoms of adverse drug reactions such as akathisia that are associated with the use of SSRI antidepressants.

Considering all the risk factors associated with the use of SSRI antidepressants both myself and my family feel they should be reserved for the treatment of severe and treatment resistant depressive disorders. A report by the Australian Commission on safety and quality and healthcare dated June 2017 entitled, 'Medication Safety in Mental Health' states that 86 per cent of psychotropic medicines are prescribed by general practitioners and that antidepressant use has increased tenfold since 1990. We believe that general practitioners should be allowed to concentrate on diagnosing physical illnesses and that the diagnosis of mental health disorders should be left to practitioners such as psychiatrists and clinical psychologists who have received an extra five years of training in the diagnosis and treatment of mental illness.

PROF KING: Thank you very much, Ms Spinks, and thank you for coming in and sharing your story with us today. Just to clarify before I pass over to my colleagues, so as I understand the pharmacist who filled the prescription as far as you're aware there was no offer made by that pharmacist of the consumer product information sheet associated with the medication.

MS SPINKS: No, and in fact when my daughter rang up and spoke with one of the pharmacists she was advised that it was - you know, even though she was saying she was having reactions she was advised she could just take it that night, that would be fine, she would have the side effects while she slept. The pharmacist displayed no knowledge of akathisia or adverse drug reactions whatsoever. I did complain to the Pharmacy Board she has been counselled apparently but still it's very disturbing that this knowledge of adverse drug reactions seem to be very, very limited amongst, you know, generally the practitioners who are working in it and I believe, you know, in the Medication Safety and Mental Health Report they give quite a lot of instances where polypharmacy is practiced and the adverse drug reactions are not recognised so when somebody says presents with psychosis then they get another drug for psychosis on top of the one they're already taking and they're not recognising maybe an adverse reaction to the drug that they'd first been given. It seems to be a big problem.

PROF KING: Yes, and the reason why I stress that consumer product information, you may be aware of it from other medications, it's basically a white sheet but it lists out the various side effects and risks associated with the medication.

MS SPINKS: That's right, she was given nothing and this is my contention that, you know, as a safety measure there should be a warning in the packet and all the other countries have done that because you can't always rely on human beings to remember. You know, I mean, it might have been a busy day for the pharmacist who knows, you know. I mean, it's just - - -

PROF KING: But there should be safety measures.

MS SPINKS: - - - a safety measure that I can't understand why the Therapeutic Goods Administration is not providing it, I really can't. It doesn't make any sense.

PROF KING: Yes okay.

MS ABRAMSON: Thank you. On behalf of the Commission, Ms Spinks, can I acknowledge your loss, we are sorry that that has happened and coming today is a constructive thing to talk to us. I want to talk to you about a very small aspect of it and I've understood what you've said about the drugs and I'll ask my colleague, Professor Whiteford. The coroner's report, so on what basis were you allowed to appear (indistinct words)?

MS SPINKS: We were just never invited, we were never invited. In fact, you know, it took quite a while for me to even get the report about her death and they didn't seem to need to include family members, we weren't included at all. It was only when I asked at pharmacogenetic testing that I got the doctor's expert witness statement that he provided and realised that, you know, the information wasn't - you know, wasn't what we saw, you know, in my daughter who usually is very well but had just been so very ill.

MS ABRAMSON: Thank you, Ms Spinks.

PROF WHITEFORD: Thanks for telling us this story. It's, you know, an example of the tragedies that occur in the mental health system. Just one more question about the pack that your daughter got. So there was no provided information inside the packet or there was no - - -

MS SPINKS: No, nothing.

PROF WHITEFORD: It's unusual because that's a requirement that that goes in those packs and why it was removed in your daughter's case is something - - -

MS SPINKS: When I went and checked with Chemist Warehouse and got a - you know, said, 'Packet of Zoloft, is there a product information sheet contained within it?' and she got the packet out, no, there wasn't, no.

PROF KING: And even though you'd asked that question the pharmacist did not give you a separate consumer product - - -

MS SPINKS: Well, I wasn't prescribed Zoloft so I was just asking her. You know, I was asking because I wanted to check that out. Was it just my daughter or is this - you know, and since I've checked and in Australia apparently there's no requirement for this.

PROF KING: Okay.

PROF WHITEFORD: Thank you, we will take that. So the other question I suppose is the issue you raised about medications being given for mental health problems too liberally or when non-pharmacological treatments would be more appropriate or where there are physical illnesses which might initially manifest some symptoms that could be seen to be a primary psychiatric (indistinct words) for us. One of the things we have made is a recommendation on this to try and increase access to non-pharmacological treatments and so for busy GPs perhaps the temptation is to prescribe medication when other kinds of psychological treatments would be the first line of treatment versus College of Psychiatrists (indistinct words) recommended so picked up on that information and recommendations that have been made to us and we've

tried to put provisions in the recommendations that we've made about the system to increase the options available to general practitioner.

MS SPINKS: And could I just say that when you say somebody has a chemical imbalance in their brain and that a medication will fix that chemical imbalance there's absolutely no point in going for psychotherapy if you think there's something actually wrong with your brain. It's a very - takes away hope for a patient to tell them that and in actual fact there's no evidence been found for it so I just feel that that tool for diagnosis is really harmful in so many ways and it really is a very simple explanation for what is a really complex problem and it's really sad that it's on the adverts, you can see it on the Zoloft ads in the USA, can get them on YouTube, you know, that's what they're promoting but - you know, and then Dr Breggin has had access to their drug company trials and records which, I mean, I know they do their own trials and evaluate their own products so, I mean, he's had access to that and he says there's no evidence to support that.

MR THOMPSON: Could I just say (indistinct words)?

PROF KING: Because of a transcript, if you hold on I'll ask you to come up just at the end of Ms Spinks, yes.

MS SPINKS: My daughter's brother.

PROF KING: Okay, yes, so I'll ask you to come up just in a minute.

MR THOMPSON: No problems.

PROF KING: Any other questions for me? Thank you, Ms Spinks. If you wouldn't mind coming down and just your name for the transcript.

MR THOMPSON: Yes, Your Honour. So my name is Ian Thompson so I'm the son of Emma Spinks and Jackie's brother. So just one extra point I wanted to raise there about what you raised. To me the doctor didn't even make the right mental diagnosis. She wasn't depressed, she had anxiety. And every interaction we had with her towards that stage she demonstrated that anxiety from her illness, from her physical illness, so if the doctor hasn't even had the chance to properly diagnosis her mental condition I agree with what you're saying and, you know, it went to a solution too fast when it should have gone through alternative therapies and a proper diagnosis of where she was mentally because if you don't even know what disorders you've got how can you treat it?

PROF WHITEFORD: So I think you're just reiterating what I said (indistinct words) consistent with what you fed back to us so clearly the appropriate course what we are recommending would be that an appropriate diagnosis is made and that includes the identification of any physical illness which is presenting with psychological symptoms and then secondarily if there is a primary mental health problem, that non-pharmacological treatments should be the first line of treatment for most of those and as Ms Spinks said that pharmacological treatments should be only used when they are the necessary treatment and shouldn't be provided prematurely when they're not the first line of treatment that should be recommended.

MR THOMPSON: Agreed, yes, thank you.

PROF KING: Thank you.

MR THOMPSON: Thank you.

PROF KING: Next, Daniel Comensoli and Lucy Abbott. And if you could state your names and any organisation you're representing and any opening comments like you'd to make.

MR COMENSOLI: I am Daniel Comensoli and I'm the policy and research coordinator at the Alliance.

MS ABBOTT: And I'm Lucy Abbott, I'm the director of programs and development of the National LGBTI Health Alliance.

PROF KING: Thank you.

MS ABBOTT: Firstly, I'd like to acknowledge the traditional owners of the land on which we're meeting today, the Gadigal of the Eora Nation, and to pay my respects to Elders past, present and emerging and I think the Commission for the opportunity to speak here today. The National LGBTI Health Alliance is the national peak health organisation in Australia that provides a national focus to improve health outcomes for LGBTI people through policy, advocacy, representation, research evidence or capacity building.

We welcome the release of Productivity Commission's draft report and its recognition that LGBTI people are a priority population for consideration and action. It's also reassuring to see the Commission recognising the need to improve access to appropriate services and to have a well trained workforce to provide high quality and culturally safe services to LGBTI people. However, if we are truly going to improve our community's mental health and wellbeing we need to go much further and talk about and address the causal factors.

Therefore we would like to use the limited time we have today to talk more broadly about the structural and societal barriers that contribute to LGBTI people being more at risk of poor mental health and suicidal behaviours. We know that these poorer health outcomes can be attributed to the impact of minority stress. Minority stress is the chronic stressors that LGBTI are uniquely exposed to as a result of the social stigma associated with sexuality, gender and bodily diversity. This includes experiences of discrimination, social exclusion, harassment and physical violence. Responding to these determinants is complex and is made more difficult when we live in the shadows of government processes and legislation that seek to entrench discrimination in society more broadly as well as within health and other much needed wellbeing and social services in schools.

We note the draft report's recommendation for routine data collection and its acknowledgement that significant knowledge gaps remain. One of those gaps is the census. Currently the census does not capture data on sexual orientation, gender identity and intersex status of the Australian population. This exclusion means that vital data indicators will remain excluded from important datasets that are used across community, primary and tertiary healthcare services and

programs. Asking appropriate questions on sexual orientation, gender identity and intersex status in a census is crucial in fostering an evidence informed environment for health and economic policy service planning and understanding health and social service utilisation.

This is essential if we are to better manage the mental health of LGBTI people in communities. The welcomed focus on working toward zero suicides relies on good data; data linkage, access to current data such as coroner's data to assist in preventing suicides will not benefit our communities. We have higher rates of suicide and we need to benefit from good data. The only way to achieve this is by including these questions in the 2021 census as is in the case in New Zealand and the UK so that they can then be included in other datasets with consistency. We are seeking to have the same playing field that others have to work with to reduce the number of suicide attempts in our communities.

Australian and international researches consistently show that LGBTI people underutilise health services and delay seeking support due to actual or anticipated discrimination or stigma from service providers. In private lives, for example, in private lives too - 34 per cent of LGBTI Australians reported usually or occasionally hiding their sexual orientation or gender identity when accessing services to avoid possible discrimination and/or abuse. The Trans Pathway study found that 42.1 per cent of trans young people encountered mental health and other medical services who 'did not understand, respect or have previous experience with gender diverse people'.

Further, 60.1 per cent of study participants experience feelings of isolation from these services which was found to be linked to higher rates of self-harm, suicidal thoughts, suicide attempts and diagnosis of PTSD and anxiety. Alarmingly a recent study undertaken by La Trobe University in partnership with Lifeline Australia, QLife and ACON reported that 71 per cent of sexuality and gender diverse people choose not to use a crisis service support during their most recent personal mental health crisis to beat that 71 per cent.

35.2 per cent reported barriers that prevented them from accessing a service and 21 per cent felt unsafe while accessing a service. Healthcare research has demonstrated that disclosing your sexuality and gender identity to your regular GP is conducive to increase positive health outcomes therefore its vital need to work with LGPTI people in a culturally safe way. Fear of discrimination such as withdrawal of a care may lead LGBTI people to have difficulty disclosing even where they believe these issues are directly relevant to the detriment of their care.

It is also important that LGBTI people are able to be their authentic selves when accessing healthcare services so we can access holistic healthcare. The disclosure of being LGBTI, for example, will alert the practitioner to a number of considerations, for example, mental health given our disparities. The government's proposed religious discrimination bill entrenches discriminatory access barriers to healthcare for LGBTI people by allowing healthcare practitioners to conscientiously object to providing much needed healthcare to our communities.

The Bill will have the undesirable consequence of deterring governments efforts to reach, for example, its ambitious goal of zero suicides in Australia as well as the other priorities that are outlined in numerous health and wellbeing national strategies. We are also concerned that the

healthcare provisions have the real likelihood of adding to the determinants that already place LGBTI people at a higher risk of suicide than their non-LGBTI counterparts.

There needs to be a nationally coordinated approach to LGBTI health to ensure that money is better invested into our communities to effectively respond to the significant health disparities we experienced. Currently there is no national coordination of goals and targets outlined in the national health and wellbeing strategies where we are identified as a priority population. We also need national coordination of LGBTI research in this country as we have a somewhat siloed approach.

The Alliance is attempting to bring all LGBTI health researchers together and our capacity to do this is hampered without the resources to do this. Other bodies are able to undertake this important work as well as other important national peak functions because of core funding. Peak funding for the Alliance would enable us to undertake much needed coordination in LGBTI health as well as meet the demands of members, governments and other stakeholders that rightly reach out to the alliances of the national LGBTI health peak body.

There is also a vital need for greater investment at the national level to ensure LGBTI people could contribute and engage in robust and constructive participation in developing policies, initiatives and programs relevant to their own mental health. It is important to also acknowledge that at the jurisdictional level there is a need for greater investment in LGBTI health so that there can be sustained and equitable access across Australia to community controlled peer based programs. There's not one of the Alliance's full members who are all LGBTI health organisations that are properly funded to meet the mental health needs of our communities. This includes, for example, across ageing programs, general health and wellbeing services, drug and alcohol, social inclusion and safety and access to general services.

Overall the Alliance believes that a strategic and coordinated approach which considers meaningful change (indistinct words) community and social level is needed to address the health disparities that exist between LGBTI populations and the general community. This will require an effort across multiple sectors beyond health including education, employment, social services, housing and justice. A paradigm shift that decentres heteronormativity and embraces sexuality, gender and bodily diversity coupled with a connection of quality and robust (indistinct words) evidence will help increase social inclusion and reduce stigma and discrimination in the lives of LGBTI people. These measures will result in a more supporting and accepting societal environment that will act as a protective factor for the mental health and wellbeing of LGBTI people. Thank you.

PROF KING: Thank you. Can I start by asking - so we've looked at some issues of stigma and discrimination but for stigma and discrimination associated with mental illness rather than sexual orientation. I agree with you that to make a difference we need, you know, to be working across health education, work, justice, increase social inclusion. I guess everyone agrees - well, I hope most people, well not everyone, but most people agree with the goal how do we get there, I guess. So what do you want us to recommend to government next May that will make a difference?

MR COMENSOLI: Well, like Lucy alerted to you earlier the census would be a great start because as we say the census (indistinct) LGBTI indicators in the census is the key to the door to other datasets and what the census does is it provides the broad overarching data indicators that can be then be embedded in other datasets of the mental health services, drug and alcohol services and other health services. And also to the service provider level as well, without explicit inclusive policies, structures and data collection practices LGBTI people - all clients remain fearful, fearful of being discriminated against and in order to protect themselves they then hide and modify their identities, their experiences, their histories and that renders themselves invisible basically and then that can lead service providers to then assume that they don't have any LGBTI clients and therefore they don't need to consider them in service planning or service provision and so you see this cycle of invisibility that is occurring and what is key to sort of breaking down that cycle is good data and currently we don't have good data for our populations and because at a higher policy level we don't have - there is little to no data of LGBTI populations, there is limited evidence (indistinct) that would need for mental health services and that means that LGBTI operations are excluded from policy creation, implementation or valuation and - - -

PROF KING: Can I follow that up, so I think that is a really good idea at a population level but you also mentioned, you know, in a sense data collection at the individual level.

MR COMENSOLI: Yes.

PROF KING: Do there need to be sort of safeguards in there? I mean, in some other areas there's talk about data ownership, data rights, and so on so do you think if, you know, there's procedures put in place, for example, so that GPs, for example, regularly collect information on a patient's sexual orientation but there'd need to - well, do there need to be protections in there from the consumer's perspective so they feel comfortable to - - -

MR COMENSOLI: Yes, I think so. And, yes, the key to that I guess when questions are asked usually they're not appropriate and they're not accurately capturing the population that they're trying to capture so there just needs to be collected in a meaningful and appropriate way and that is in collaboration with LGBTI communities.

MS ABBOTT: So, for example, we heard recently at the AusPATH trans health conference that it's broad practice that GPs of trans people getting prescriptions for hormones, they're subject to genital examinations; completely not required, you know, traumatising and potentially abusive and we found that's a common practice.

MR COMENSOLI: There also, just one example as well, like in 2016 the ABS tried to be inclusive or within the sex question they asked, 'Are you male or female?' and then they had the third response option which was 'Other' and then in order to disclose another identity you had to ring up a separate phone line and then get a separate form printed out and the ABS has acknowledged that that approach didn't work and there was significant underreporting of trans populations in sex populations so it's sometimes better to not ask at all than to ask in a potentially harmful way so, yes, I guess it has implications for local health districts (indistinct words) who are crying out for this start-up.

We had recently an example where one of our member organisations engaged with local health district in Sydney, the priority population's in it actually, when they were writing their report on priority population LGBTI-type people weren't identified even though that district has one of the largest LGBTI populations on Australia and their reasoning was that, 'Well, the foundation for that report was based on 2016 census (indistinct) and because we weren't counted in census (indistinct) we weren't identified as a priority population which than implications for service planning and policies.

PROF KING: Yes, good.

MS ABRAMSON: Thank you very much for appearing today and hearing a well conversed submission from you with some practical recommendations as to what you'd like to see. We've had quite a strong vote for rural and regional Australia and getting services to (indistinct words). You've spoken about stigma and difficulty within urban - I mean, I'm making an assumption here - but urban settings with (indistinct words) you referred to; what more can we do in terms of supporting people in rural and regional Australia?

MS ABBOTT: I think the expansions of perhaps services that do target those areas and I think some of the biggest issues in rural remote areas are confidentiality and privacy so the Alliance coordinates and provides national support for QLife which is the telephone and webchat service. We know from our data from that that in the country areas people prefer webchat than the phone and that could be a connectivity thing so there's IT issues for telehealth and all those things that people need in rural remote areas compounded with privacy and confidentiality issues and then access to proper services so if your life is chronically - you know, half of our calls go answered because chronic, you know, funding issues.

I mean, it's not just about funding but it's about wraparound services for people and the fact that Lifeline refer to QLife, you know, those kind of instances where you've already got a very well funded national service and it's referring on to a service that is very poorly resourced and isn't a crisis services because it's not 24 hours. So it's kind of we need (indistinct words) services but we also need mainstream services to be more aware and to be trained, particularly the medical world.

MR COMENSOLI: Yes, I was just going to say that. Within a skilled and knowledgeable workforce who are aware of LGBTI issues and that's made more difficult in regional and rural areas where their services are scarce. I lost my train of thought, but - so just like the proposed Religious Discrimination Bill we have a provision in there that will allow mental healthcare practitioners to refuse services based on the personal religious belief and that has an impact in our communities and - especially in regional and rural areas where there are not that many services so - like, in a publicly funded health system we should be aiming towards improving access to health services and not winding its back. I mean, there are fundamental structural barriers in place already for LGBTI people and we need to be working harder to break those down and not entrench them in legislation.

MS ABRAMSON: On the lines services, because the Commission has such a strong focus on it, what you just said with Lifeline is very interesting for us because we've also heard that there's for some CALD communities Lifeline is not necessarily a good option so practical recommendations that you've just outlined to me is - and it would very helpful, thank you.

MS ABBOTT: I mean, one things in terms of the workforce and I think in relation to the bill, it's for the government to build confidence of the community. Like, the community do not have confidence in this government for a lot of reasons. There's historic reasons, there's a long, hard horrible history of discrimination and abuse but if you're looking at things like the community benefitting from something like My Health Record - like, our community are not going to register for My - they are opting out at high rates because they don't have the confidence in the government and when you've got Bills like the Religious Freedom Bill, the marriage equality vote, those things do not build confidence in communities then you're being kind of having to work extra hard to kind of - it's a bit damage control isn't it.

MS ABRAMSON: Can I ask you before passing you to my college to take something on notice as we're a little bit pressed for time. Workplaces: we have a very strong focus on equally healthy workplace and a number of companies have a range of policies which say that they will behave in a certain way and in some cases that's not the experience of the people in the workplace so (indistinct words) your recommendations around that would be - - -

MS ABBOTT: Great.

MR COMENSOLI: Thank you.

PROF KING: One quick question about data. So I know that consideration is being given to a question in the upcoming census, 2021 census, and I know from just checking my mind that there was a question within a social survey (indistinct words) survey in 2014.

MR COMENSOLI: Sexual orientation from my understanding, yes.

PROF KING: Right. And there is a new ABS survey (indistinct words) will be going into the field late 2020 so it would be, I think, useful to check the question that was in the survey in your view about what it was appropriate to cover the issues (indistinct words) and then also says whether the ABS would put a question in the (indistinct words).

MR COMENSOLI: Yes, that's a really good point. Like, the Alliance has been engaged now in a sensitive consultation process with the ABS which has been really great and that's been in collaboration with the Australian Rights Commission and Intersex Human Rights Australia, it's an interesting point that one of you raise about the general social survey because that's kind of put out there as, 'Oh, well we're collecting it in this way so why do you need it in a census?' so the general social survey only does ask about sexual orientation but what the census is that it manages to collect data at the small geographic level which the general social survey doesn't and that's really important in sort of directing investment and targeting services to those smaller areas so that's why we need those questions in there in 2021.

MS ABRAMSON: Thank you.

MR COMENSOLI: Thank you so much.

PROF KING: Thank you very much.

MS ABBOTT: Thank you.

PROF KING: Next, Matthew Fitzpatrick. And if you are able to state your name, if you're representing an organisation the organisation and any opening comments that you'd like the on the transcript.

MR FITZPATRICK: My name is Matthew Robert Fitzpatrick and I'm 61 years old. I have been diagnosed with a number of different mental illnesses that I don't have, right, of course most of them being schizophrenia which is a common one and bipolar as well. Now, I'm not on any medication at all at this very moment, not even non-psychotic medication. Okay, and actually I've spent 24 years in the army. I joined in 1980 and was discharged in 2004, okay, so all these diagnoses come late in life. Now, what's happened is that I have over time suffered from depression that through my recent research I've come to the conclusion that that's all about sleep due to the fact that I've never been a good sleeper so if there's problems going on then I'm not getting sleep for days, so. And since then I've come to the conclusion that both diet and exercise is much more important than what people realise and what I previously realised as well so I've got a 29 inch waist, I got to 37 inches, that's not pant size that's with the tape measure and I managed to bring that back to my 20 year old self - - -

MS ABRAMSON: I'm looking with great interest at you.

MR FITZPATRICK: All right. Okay, where were we. All right, yes so anyway one of the biggest problems that I find is the accuracy of the data, okay, and therefore the accuracy of the diagnosis and I also feel there's two different types of psychiatrists, there's the mainstream majority and the minority of progressive ones that are forward in modern thinking and the mainstream it's all about medication, getting people on medication as quick as possible and that's it.

But the other situation with this accuracy of data - and that's the reason why I believe that all psychiatric interviews should be audio video recorded because I feel that that would promote them to record more accurate, to listen more carefully and to pay attention to what's going on.

PROF KING: Can I just acknowledges a question about that? Should that be at choice of the consumer, of the patient?

MR FITZPATRICK: Well, I think, yes, it would but I really don't see that many people would have a problem with it. For example, it's acknowledged that there's this situation where people with mental illness on medication are more likely to be in the court system and the gaol system. Well, the court system they're recorded anyway so you haven't got a choice for this audio video recording.

PROF KING: Sorry, I interrupted, so sorry.

MR FITZPATRICK: No, no, that's all right. And as well as that if you look on YouTube you will find recordings of psychiatric interviews on YouTube going back to black and white from the fifties or whatever as well. But also there's this crime situation because you often hear on the news that someone that's been charged with something is suddenly claiming mental

illness as well. Actually very recently someone that got a non-sentence for assaulting an ambulance officer, it was appealed and now the person's been diagnosed with schizophrenia after it was appealed whereas when he was sentenced he wasn't diagnosed with schizophrenia and now they're saying, 'We're appealing it' then he's diagnosed with schizophrenia so I'm not saying he's not schizophrenic but I'm saying it looks very sus.

So there's also that aspect and as well as that this would give you - there's this debate starting to happen about the safety of this medication as to, 'Does it cause suicidal thoughts, homicidal thoughts?' and I'm with the people who say it does, all right, so in that situation there just say someone does commit suicide if you've got all the full recordings, audio video recordings, of the interviews with the psychiatrists you can then go back and do a very comprehensive assessment of, 'Should the person have been on the medication? Could we have done things different?' and that sort of thing but at the moment we've only got what are called 'self-critiquing' which is the psychiatrist self-critiquing their medication prescribing skills because they're the ones that are judging themselves because there's no test.

It's not like if you went to the doctor with blood tests and then - for example, high blood pressure. If someone's got high pressure they're put on medication and you come back, they do a test and they can tell whether the medication is working or not from that test. There's no test, it's just what the psychiatrists record and I think some of the exaggeration that's being put in there is actually to protect themselves because they're prescribing these dangerous medications by exaggerating the situation and saying, 'Well, this person should be on the medication' because they're riding in a way that suggests that the person should be on the medication but that may not be the case.

PROF KING: Okay.

MR FITZPATRICK: All right, now the other thing is I'm concerned about this screening children for emotional wellness checks because my view of a psychiatrist diagnosis it's a bit like fishing with a net. Yes, you're going to catch the people but you're also going to catch - there's going to be collateral damage, you're going to catch others as well like other fish and plastic and marine life when they're fishing and it also depends on the grid of the net as to what you catch and so what I'm saying with that is different psychiatrists, it's basically in a different grid in the net because they can't all be exactly the same standard and views on this - yes, anyway, so for that reason I think that I'm alarmed by this because I think there's going to be people who get involved in the mental health system that shouldn't be and the other problem is that parents probably not wanting to hear that they're doing something wrong especially like with the diet because I think everyone would agree that- well, most people would agree that the diets are getting worse and worse and worse.

I mean, you've only got to travel on a train around when school's finished to see what kids are eating. They've got a can of V - like, an energy drink or something like that and they're 14 so, yes, so - and the problem is is that parents don't want to hear that there's some sort of medical reason for their child not feeling well, misbehaving, so there could be a tendency for the parent to actually want medication when it's not necessary as well. The child's brain's developing so you're giving this chemical imbalancing drug to a developing brain and also you're giving them stimulants so there has to be a tendency for them to be seeking out stimulants like ice when

they're a teenager, when they're older, because they've taking as a child, the stimulants, so I'm alarmed at that.

I haven't sort of checked too much into it so I won't say anymore on that.

PROF KING: That's fine, yes.

MR FITZPATRICK: But, anyway, I am alarmed on that. Now, on page 64 and 397 there's a reference to GPs managing the drug side of things. The problem with that is that it doesn't really say anymore but that's just going to be with another medication because that's generally how side effects are managed. Now, in my - on my online submission, was number 358, in that submission I actually tried to say as little myself and left it to more professional people because I haven't got any medical background at all except for first aid training.

Now, one of the documentaries I put in there was 'The Hidden Enemy' and it's to do with basically the American military and psychiatry but there's other military people talking about how bad psychiatry is as well and in particular the drugs and how bad the drugs actually are. Now, - - -

MS ABRAMSON: Mr Fitzpatrick, I'm sorry to interrupt you but you can take it that we read that submission so you can take it that we are aware of those things.

MR FITZPATRICK: Yes. Yes, all right. But what's actually happened in there is that there's been young soldiers that end up on over 20 medications so they're given a medication side effect and then more medications - well, they've actually - well, you've got young healthy people dying from having over 20 medications in their sleep and they're taking it as prescribed so, yes, so just saying that a psychiatrist prescribing a drug and then saying, 'Well, it's up to the GP' it seems like it's palming the problem off to the GP with the side effect situation. But anyway - - -

PROF KING: I think you wanted to - I'm just aware of the time I think you also wanted to talk about non-drug treatments not being available.

MR FITZPATRICK: Yes, yes, I actually do. In that submission I showed where fasting was tried as a treatment starting in the Soviet Union and Japanese study has backed it up, okay. Well, since then I've actually, with not seeing a reference in it, I've actually seen more on that. Now, what I've actually - and for me, I've gone gradually gone to the one meal a day diet so I'm only eating once a day so I have to eat fairly well so I'm fasting for - so it's called a 'practising intermittent fasting' and every now and then I do a five day fast so that's me, and that gradually come in, but since I've been I've found that this has actually been tried and these are recent articles. This one here is 21 January 2019.

PROF KING: Did you want to pass them up, or?

MR FITZPATRICK: Sorry?

PROF KING: Did you want to submit the articles formally, or?

MR FITZPATRICK: Well, what might be better if I email it in.

PROF KING: Yes, I think that's best, yes.

MR FITZPATRICK: And in the printing of this this has actually skipped some lines so this is the one here on the ketogenic diet - - -

PROF KING: Yes, probably best if you can email us the links rather than going through the article.

MS ABRAMSON: Excuse, Mr Fitzpatrick - - -

MR FITZPATRICK: Yes, I will actually be doing that and here's another one - sorry.

MS ABRAMSON: Sorry, can I just summarise your evidence to assist you. Really you're saying there are other treatments that are available and diets (indistinct words).

MR FITZPATRICK: There is definitely and I can't understand why - well, I think I can understand but it's conspiracy type stuff to say why psychiatry is ignoring this. Now, this other one here - and they've actually given examples - exercise and fasting leads to brain detox. So - - -

MS ABRAMSON: What we would welcome, Mr Fitzpatrick, is if you'd like to put them into a formal submission and we'll certainly have a look at them but you've brought a point - we understand what you have very helpfully said to us about other treatments. I did want to ask you if I may about mental health tribunal because I understand that you wanted to speak in respect of advocacy (indistinct words).

MR FITZPATRICK: Right, I'll just quickly finish on this first because it goes a little bit deeper and then I will get on to that. Here's another one here, 'Chronic schizophrenia put into remission without medication'; this is the keto diet. Now the similarities between the keto diet and fasting is that you start burning ketones so they're both similar in that way so this is further evidence of fasting will cure schizophrenia.

Now, the other thing quickly. My experience in the mental health hospitals is that there's an extreme sugar consumption around people who are mentally ill. Now, I'm talking about having like ten more teaspoons of sugar in a coffee, there's extremes. Well, what I've found is that insulin resistance is a hallmark because these are all recent articles. This is 4 April 2019, 'Insulin resistance; a hallmark of schizophrenia'. As well this says, 'Abnormal insulin levels founds in first episode of schizophrenia sufferers' so I'm starting to conclude that sugar could actually have a causal effect in this happening as well but not only sugar it's also processed carbohydrates as well.

PROF WHITEFORD: Mr Fitzpatrick, sorry for interrupting. Well, what the clinical information we'd have to take from (indistinct words) we're not a clinical group here so a recommendation is more at a certain system level so can I just stop you there and ask you one question before you finish. In the interactions you've had with the mental health system is there

any recommendation about, not from the clinical point of view, but from a service point of view that would have made it a better outcome for you?

MR FITZPATRICK: Well, the first problem is they start to medicate you from day one - - -

PROF WHITEFORD: Okay, so let's stay with that. So without now not going to the medication or drug therapy as the first choice but looking at options first?

MR FITZPATRICK: Well, there are no other options.

PROF WHITEFORD: Psychological treatments?

MR FITZPATRICK: Well, I'm not aware of that. My experience is that they're wanting to drug me from day one.

PROF WHITEFORD: Right, okay.

MR FITZPATRICK: The other huge problem is the delusional issue because you can be held in a mental hospital having delusions alone so that's a problem there because when you go - and the recordings in their file, they don't even have to record what the delusion is so they can just right down, 'Delusion - - -

PROF WHITEFORD: So are you saying under the system you weren't given an option for non-pharmacological treatment, just like you just said to me; is there anything else about the treatment system which we could take onboard to try and make it improved?

MR FITZPATRICK: Well, the problem is with these mental health review tribunals they've already started drugging the person before the tribunal. The other thing is that I don't know whether this my words, the targeted report thing, but they right a targeted report, the psychiatrist, and they won't give you any information on you so you're turning up for this mental health review tribunal not knowing anything or what's going to happen in there or being said so - - -

PROF WHITEFORD: Yes, we've heard there have been some recommendations given to us about how those tribunals could work better so we'll certainly be taking that onboard. We're about to run out of time. Is there one last comment you want to make before we finish?

MS ABRAMSON: And we've all read your submission.

MR FITZPATRICK: Right. Okay, well the complaint system is not - the Health Care Complaints Commission is the Health Care Coverup Commission'; that's my view because they are just so bad. Like, they use this, whatever they call it, by saying, 'We've only got 13 staff to deal with 6000 complaints. We can't do a better job on the complaint' but what they want to do is let as much as possible slide in favour of the psychiatrist and what they'll actually do is they'll actually change the nature of the complaint in their letter back so the classic example - and when you've put in a number of complaints you see a pattern.

Putting in one complaint you can't see a pattern. It's only when you put in a series that you're going to see a pattern so I've seen a pattern from that. They'll actually change the nature of your complaint so what they'll say, and it's in their letter, 'We understand your complaint. There's this' and in my case it was - because what happened was that - like from complaining about a public servant who was corrupt to medical health workers they actually had me admitted for that because they didn't like me doing that. I know this sounds strange but they were hell bent on having me admitted so what I did is I put in this complaint about how they knowingly misrepresented what I'd said because my life is actually - if you go deeper into you will find out that it's definitely like a movie. So in saying about my life being like a movie they made out that they actually believed that I was delusional and thought that my life was actually being made into a movie at this time and used that as evidence to have me admitted, all right, and - - -

PROF KING: Right, eventually - - -

MR FITZPATRICK: Yes, and so what they did is they turned around and said, 'We understand your complaint. This worker', because I won't mention any names, 'misunderstood what you said' and I used the word 'misrepresented' not misunderstood.

PROF KING: Yes, I understand what you're saying.

MR FITZPATRICK: So they'll actually even change the nature of your complaint just to let it slide in favour of the other person.

PROF KING: All right. Well, we'll - - -

MR FITZPATRICK: But as well as that, quickly, on the complaints system, it's a fractured complaint system as well because not only do you have the Health Care Complaints Commission you have the Privacy Commission and they can actually fine you for putting in a complaint.

MS ABRAMSON: Mr Fitzpatrick, we've heard what you've said to us. It's important evidence. We're just mindful that there are a number of people who want to talk.

MR FITZPATRICK: All right.

MS ABRAMSON: But we will absolutely read your submission.

PROF KING: Yes, so if you can put in a submission with those links that would be fantastic.

MR FITZPATRICK: Part of the problem is I don't consider myself a very good writer, I'm better with my hands so it takes a lot of work but with the Privacy Commission thing, they're there for complaints on accuracy but if they believe that your complaint is frivolous or there's no substance in it they can turn around and charge you for putting in this complaint.

MS ABRAMSON: Mr Fitzpatrick, we will read it, thank you.

PROF KING: Thank you, Mr Fitzpatrick.

MR FITZPATRICK: All right.

MS ABRAMSON: Thank you.

MR FITZPATRICK: Okay, thanks.

PROF KING: Next we have Jeni Diekman.

MS DIEKMAN: Thank you.

PROF KING: And if you could state your name, any organisation you're representing and any opening remarks for the transcript. Thank you.

MS DIEKMAN: Thank you, Stephen, and thank you for allowing me to speak today. Yes, my name is Jeni Diekman. I'm a community pharmacist and also the carer of family members with severe mental illness complicated by drug and alcohol abuse. I really commend the report, the detailed examination that (indistinct words) mental health services in Australia. I've (indistinct) many of their recommendations but I'll have some comments about some of those recommendations that hopefully will lead to an improvement of the coordination of services for the consumer.

However, I think there was a significant gap in the report as it related to community pharmacy. The report says that pharmacists dispense and give advice on drugs and I want to demonstrate to you what I do in my pharmacy to show you the value of a network of community pharmacies and the pharmacies that are at the coalface in primary health care and argue that their current funding arrangements in community pharmacy does little to encourage the delivery of the type of care that people with mental illness deserve and as we've seen today with Emma, I'm very sorry to hear about the essence with one my colleagues, but I think that that will probably support my case for the way in which the funding of community pharmacy at the moment.

So what I'm going to do is I'm going to show what I do in my pharmacy with people that present at the various stages of the stepped care model. So if we start with the health information stage. I speak to people - for instance, they might come in with a sleeping problem. Now, it's very easy just to say, 'Okay, I can give you a Restavit. I don't do that. I like to find out what the sleeping problem is, I let them know that sleep deprivation can lead to mental illness and that there are various things that they can do before they need to take an over the counter medication like relaxation techniques, there's a whole thing they can do with sleep. We talk about weight and nutrition, smoPROF KINGessation and drug and alcohol misuse that might be contributing to those problems.

So we can give a lot of wellness information. It's not just about illness. Then in the early needs stage where you are putting the use of the digital health agency, that's where pharmacists - I recommend regularly for people to use the Head to Health website and we can promote it. We also provide written resources such as the Beyond Blue booklets on what works for anxiety or what works for depression and also the information resources that are available for consumer and the family. I can refer to the NewAccess program (indistinct words) health network, I've only just found out about that though.

And where my pharmacy is we have a lot of university students and we recommend that they can seek out headspace however I've had a recent instance where I have a 12 year old boy who had very complex family issues who was being bullied at school. Now, he did have a counsellor at school but the counsellor only came every three weeks but with these complex family issues he was developing extreme anxiety and I was trying to get him into headspace. Headspace referred to the CESPHE, PSS, or whatever it's called, then they decided to refer it back to headspace. It's now five weeks later and he's still not had management of his anxiety and he's now not going to school because he fears being bullied.

Then with low intensity mental ill health and I'm just going to mild, direct and low intensity where by that stage the person is usually seeking the help of a psychologist or a general practitioner and the person would come to the pharmacy usually for prescription medicine. Now, in my pharmacy they do receive a consumer medicine information sheet. In many of the generic medicines they don't have consumer medicine information sheets and my staff are trained to offer the consumer medicine information sheet with every patient and we print it off and we sit down with the person particularly if it's the first time they've had the medicine and explain the sorts of things that they might expect and sort of mornings.

I have argued with PSA and with government bodies that really with the dispensing fee that we are paid there needs to be some way to recognise whether the CMI is being given out with the medicine and the payments should be related to that but it isn't at the moment. We also give lifestyle advice and again ask if the person has had access to Head to Health or whether they use a psychological service because the evidence is that really the medicine doesn't work on its own often and the best evidence is with both psychological support plus the medicine.

Then with high needs patients, we see a lot of patients with high needs. First of all we do dispense the medicines and we often pack them in a dosage administration aid to help them with adherence and we provide advice about the side effects. For those that are at risk of misuse, I have several patients that come into my pharmacy. They ask us to stage supply their medicines because they are frightened of suicide, they are frightened of overusing their medicines and they'll come in daily so my staff are really important in the way in which they manage their illness because they have someone to talk to and give them advice about the medicines.

We also provide needle exchange and we ask about the general health of the patient. We ask them whether they have had their Hepatitis status done. We might recommend that they have their new prescription opiate that they can use intranasally or we can ask them if they're ready to give up and they're ready to go rehab and that we can refer them. We provide opiate replacement services and the frustration - with a person that has high needs, particularly if they have a drug and alcohol problem, they have mental health problem and they now have some of the physical problems, they'll see a general practitioner, they'll see a psychiatrist, they'll see a drug and alcohol person, each time they have to go to a different place and someone with complex mental health needs it is very difficult and very demanding on them and I do note that you recommended a coordinator and I'll talk about that later.

Then of course there are the people with severe psychosocial needs. I have one patient that was in my pharmacy this week crying because he has been homeless for over a year. We tried

to get him into a place, he has his own mental health problems where he gets aggressive and they kick him out and he's back on the streets and he lives under number six archway under the light rail regularly and he just said to me - he was crying, the tears were dripping down the chair and he said, 'Look, I think I've got to go back to gaol. It's the only place I can get a roof over my head and food'.

We often develop a long term relationship with our severely mental ill patients. They often check in with us daily by phone or in person and as I said it provides a sense of security for them particularly at their most vulnerable and so I just want to show you about a recent episode where one of these high needs patients used to call us every day three times a day just to report in, ask about their medicines, but then this one day the patient rang and abused my pharmacist, it was highly abusive. This the pharmacist that would speak to him three times a day. He was so abusive the pharmacist had to say, 'Look, I can't listen to this anymore. I need to hang up' so then he rang me and started abusing me and I said to him, 'Look, this is not you. This is really not you. You really need help'.

Now, this was a patient who was in his sixties, he was a Vietnam vet, he had had alcohol and drug problems and he'd had serious abuse issues as a child. He had never seen a psychiatrist. He didn't want to see a psychiatrist. He'd never sought - and he had a very good GP but he hung up - and the GP had tried to get him to see a psychiatrist for many years - so he hung up on me and then ten minutes later he rang back and he agreed that this time he really needed help and that was because the young pharmacist - - -

MS ABRAMSON: Do you want to just take a moment?

PROF KING: Just grab - yes.

MS DIEKMAN: The young pharmacist had always been so kind.

MS ABRAMSON: You just take your time.

PROF KING: Just take your time, yes.

MS ABRAMSON: It's no problem.

MS DIEKMAN: And for the first time in the 40 years history he felt that he needed to see a psychiatrist so because of what my pharmacy had done - God, I can't believe I'm doing this - - -

MS ABRAMSON: Do you want take a pause for a minute - - -

PROF KING: Just take a break. That's fine. Just take a moment. Seriously, just take a minute, relax.

MS DIEKMAN: Thanks. They're fantastic staff.

MS ABRAMSON: It's absolutely not a problem, you take your time.

MS DIEKMAN: Basically because the pharmacist had been so caring of him, always taking time out, he made (indistinct words) his life but he sought the help this time. So the current funding model for pharmacy doesn't encourage this kind of service. It basically - it pays you for a dispensing fee, it rewards dispensing fees. There are some for sitting down with the patient, there's some money but it's miniscule compared to the dispensing fee. So the incentive is to pay the - is to dispense the drug as fast as possible, use as few pharmacists as possible and have the pharmacist check. And online pharmacy gets the same remuneration per dispense as a full service community fund like the sort of things my kids do.

And the young pharmacist today are trained to be experts in medicine management as well as in primary healthcare and by paying them to be dispense monkeys, as I call it, the government is wasting a highly trained resource. Basically those that dispense, as I've said, dispense the most prescriptions as fast as possible get the largest slice of the PSS pie and I'm really not happy about that particularly - sorry, for my most distressed patients.

I also believe that pharmacy registration should be contingent upon mental health first aid certificate and any pharmacy that's providing drug and alcohol services like needle exchange should also do comorbidity guidelines so I'm now going to lead into comorbidity, that's drug and alcohol and mental illness. You mentioned in the report that people with mental illness often abuse drugs. You know, either they can abuse drugs before they had an undiagnosed mental illness and they find substances early because certain illicit substances are great at calming the anxiety but then of course they get into the addiction and they can be going in and out of rehabs but my experience with this is that in and out of rehabs they don't necessarily look at the underlying mental health condition so if you've got someone who's clean for a week, their anxiety comes back, they're back on the drugs. They're not dealing with the mental health issue.

And it can be the other way around. They can be abusing drugs and then develop a mental illness as a result of drug abuse so our system is not developed so that you have a separation of drug and alcohol services and mental health services and it's really - that isn't appropriate, you ask in your report, 'Should drug and alcohol services be with mental illness?' and definitely, yes, I think that they must. The Matilda Centre, I'm not sure if you've had a presentation from them, I think they did do a submission but they have produced a wonderful online training program called 'Comorbidity Guidelines' and I recommend that every health professional that's dealing with people with drug and alcohol problems and/or mental health should be completing these - they have a training program and, yes, drug and alcohol services must be co-located for mental health services. At the moment there's only one dual diagnosis clinic in Sydney and from people that have used it it's been very helpful particularly if you can get young - - -

I'm not going to go into the different recommendations that you've made. Now, with draft recommendation 10.1 that digital records should facilitate information sharing. I could not agree more. However, my experience with the mental health system, in particular mental health hospitals, are that people with mental illness are asked/recommended to opt out of a My Health record. Now, these are often people who are the most vulnerable and being able to see the My Health record across the various provides, because they're all in siloes, they are going to be most helpful. However, there's discrimination against the person with mental health and even the mental health service provides are recommending people opt out so I agree that we need to have that integration but I'm - yes, anyway, that's for you.

The My Health record is not being used. Most of the people that use the My Health record are the pharmacists so all their drugs are being loaded up and the discharge summaries from hospitals but many doctors, in particular specialists, are not - and I don't even know whether they have the software to be able to load up their reports onto the My Health record - so that's a frustration of mine when I try to look at the My Health record to see what is really happening across the various providers for the person. For the pharmacists the My Health record if it was complete is fantastic because we can now see what's happening with the person, we can see their levels for instance and adjust those as creatinine levels, for instance, and adjust doses et cetera.

Your draft recommendation 11.2, increase the number of psychiatrists. If you're going to recommend that please recommend that more of them do drug and alcohol. There are not enough psychiatrists that also specialise in drug and alcohol, it's all a bit hard because those patients are not as reliable (indistinct words). Then draft recommendation 10.4, the care coordination services. That is what's needed for those that are severely ill, they need someone who can look across the various silos and bring everything together.

Now, I know in the rebuild plan you have said that. I can't see how the money is going to work for that. I really didn't understand whether the way that you're recommending the finances be allocated would lead to a coordination of services.

Now, I want to give you an example. One of my patients has a friend in The Netherlands and she had asked for this patient to go and live with her in The Netherlands. The patient had had a psychotic episode, had drug and alcohol problems, and so the person in The Netherlands said - and I said, look this patient of mine is going to need a psychiatrist and someone to deal with the drug and alcohol problems and the person in The Netherlands said, 'I can't get you a referral to a psychiatrist. It's not how it's done here. What happens here is they go into a centre and they - it's a wraparound service. So they have someone to organise their housing, someone to organise their mental health problems, someone to organise their physical needs if possible', and that's how I would like to see the mental health services delivered in Australia, and if that's what the rebuild model is going to do then that's great. Thank you.

PROF KING: Thank you very much for that. Just to summarise, because - so one of the things that I take from your presentation is that clearly the role the pharmacies have to play in the mental health system - can I summarise it by two bits. Firstly that you feel that there's more of a role that pharmacies should play - - -

MS DIEKMAN: Definitely.

PROF KING: - - - and I want to understand, because I suspect there are differences across pharmacies. Some pharmacies would like to play that role, some wouldn't. So how do we distinguish between those. And the second part is that we talk about many doorways, so the doorways through school, early education and so on. Are you also saying that in a sense pharmacies need to be an effective doorway for the mental health system broadly defined?

MS DIEKMAN: Yes, I am, and we are often - well, that's what I'm finding in my practice, because people come in with say a sleep problem or a lot of students are stressed before an exam and how can we sit down with them - - -

PROF KING: But do you think that would apply to all pharmacies, or is all pharmacy unusual, because that's what I'm trying to get at.

MS DIEKMAN: No, I don't think my pharmacy is unusual. I think you particularly find in rural areas it is - and it's definitely not the way the young pharmacists want to be able to practice. So I guess - I mean I will say something pretty outrageous here probably, and that is that the licence for the PBS licence should really go to those pharmacies that want to deliver that whole of care, because at the moment the incentive is not to do that, and that means that people are missing out for instance - not here, but, yes, because that CMI should have gone into that box, and anyone who gets their first prescription should have been sat down with the pharmacist - - -

PROF KING: In the consulting area or - - -

MS DIEKMAN: Yes, and discussed what's happening, and I would also recommend that there should be a minimum number of pharmacists for the scripts dispensed, and I don't think that an online pharmacy delivery of a medicine, particularly a first prescription mental health medicine should really happen unless there is - unless you have a Skype interaction.

MS ABRAMSON: Ms Diekman, first of all I think that your patients are very lucky to have someone who cares about them so much. I wanted to ask you about pharmacy training, because in a number of other areas we've said that - you know, with GPs, with other health professionals there needs to be more of an emphasis on training in mental health. So would you have some comments about pharmacy training.

MS DIEKMAN: No, definitely. The guild has just recently done some excellent training on the person with mental illness. The reason the pharmacist also - they need training about the person and they also need training on how they can deal with the person, for instance my patient that rang up and abused the pharmacist, because the young pharmacist often when the person with mental illness is screaming and ranting and raving at them is because of their underlying anxiety, but the young pharmacist tends to take it personally. So until the pharmacist can understand that, no, this is part of the mental illness, I don't need to get defensive, and so how the pharmacist deals with the person with mental illness there probably should be a bit more training. There is mental health first aid, but I don't think - I have done two of those courses, but they're not aimed enough at what actually happens in your pharmacy. Look, we get spat upon, we get all the sorts of things that you see with people with mental illness. It is part of their mental illness and understanding that is really important.

MS ABRAMSON: Thank you.

PROF KING: Thank you very much.

MS DIEKMAN: Thank you.

PROF KING: Next we have Mitchell Peacock, and again if you could state your name, if you're representing an organisation the organisation and any opening comments that you'd like to make for the transcript.

MR PEACOCK: So I am Mitchell John Peacock. I work in a counselling organisation just to clear the air on that one, and one of the things I've noticed with the draft is that while it's fantastic - I'm just jumping straight in.

PROF KING: Yes, please.

MR PEACOCK: While it's fantastic that it's taking a very holistic approach in caring for the mental health of the public there is a shortcoming of the role of counsellors in there. I did notice that the (indistinct) was mentioned, but it was not mentioned as something that was overly considered.

The reason why I think that we're not tapping into what I would consider to be a vital resource for the community is quite concerning on my part. The reason why I think that is a lot of counsellors focus in mental health. The draft itself - I've made notes, but I'm kind of just going off the topic already - the draft itself does talk about data and data sharing, and I think all that is fantastic, but as counsellors they're an unregistered profession at this point and they wouldn't have any access to that. So if we're looking at better ways to capture more effective data, especially when it comes to interventions, we should be able to have access to whatever data that they're holding onto and whatever they're maintaining, because that helps deliver more effective treatments. Best practice comes into results, and as previously mentioned by someone else we're not really evolving with the times. So the more we have the better it is for everyone.

I also want to talk about the cost to the public in terms of counsellors not having a rebate, as well as how it stems into the public willingness to seek help. So from a counsellor's perspective because we don't have any rebates accessible to us outside of private health (indistinct), which comes with being unregistered of course, clients might see that as a larger out of pocket expense for them. If we could look at having a rebate then we can have more people treated.

One of the things that we talk a lot about is that people aren't getting the interventions when they're required. People are leaving it far too late, and they think this out of pocket expense is one of the reasons why that's happening. Maybe they can't afford the services. In the instance of comorbidity absolutely, if they're spending a lot of their resources fuelling an addiction that's something that's going to stop them from seeking further help. In comorbidity, because they did sight out in the drug and alcohol sector, it's interesting because for those to offer free services you get a lot of people coming in - I guess mention the places I have worked in - but they were running off government grants as if that was the only way to essentially get their funding, and you could see a lot of people engaging with those services, but outside of that when it becomes an out of pocket expense you don't get as much of it, and I think that by having that rebate for enabling the public.

It also creates a level of public awareness that (indistinct) of seeing a counsellor or a psychologist is definitely not as it used to be, but by having more people have access you further reduce that, and all of a sudden it stops being you see a counsellor or you see a

psychologist, what's wrong with you, to everything else of, okay, you need this service and that's fine because it's more mainstream.

Going back a little bit to comorbidity as well, because I've written down a list of severity, because we're looking at the Stepped program. By having those early engagements and enabling people to seek help if they want to seek the help we end up having - we tackle it before we get to the high extreme. So counsellors might have their (indistinct) focus more to the low to moderate, and because I can speak from my experience I don't have a medical degree, I can't vouch for a pharmacist, I can't vouch for a psychiatrist, and I don't think that they're of not value, because they absolutely are, but I think there is a role for everyone to play, and counsellors do specialise in that face to face intervention, face to face therapy, which even a draft rec rises as effective, as well as online therapy. I have got more, but it's - - -

MS ABRAMSON: (Indistinct) a written submission if you want to make one.

PROF KING: Can I ask one question though on the data side. (Indistinct) of Productivity Commissions supported what's called a consumer data right, so the idea that - and it can be data about health, it can be data about banking, or whatever, but the consumers have rights to their data and have rights to be able to provide that data and require that data to be provided to whoever the consumer wants that data provided to. So the banking example, if you've got data with one bank about your credit history and so on you can actually say as a consumer I want you to give that data in a readable form to one of your rivals because I might want to get a loan from them. In health do you think that same sort of right might help overcome the issues that you have come across where there's data out there but you can't get access to it, and more importantly the consumer can't say, no, I want you to have access to it and that must be provided because that's my choice.

MR PEACOCK: Well, I think it goes both ways. It's not about just always providing data - well, it's not about having access to it, it's also about providing it. Our current state if the clients want us to provide data to an external source we need to have handwritten consent from them, because of course privacy and confidentiality. If that were to change I don't actually know what that would look like, though I am imagining this new system would be that there is a registry, certain people will have access to it. Clients could then confirm what they do or do not want to be uploaded to it, the same way that the current New South Wales Health works.

PROF KING: Okay. Thanks.

PROF WHITEFORD: Just one question. So the lack of registration has meant that there's not a lot of information about the, I guess consistency of counsellors across the country, so many people from different experiences, somewhat different qualifications, but I do understand there has been attempts by Australian Counselling Association and PACFA to try and look at standardising people who are members of those organisations. Can you say anything specific about that or your experience with that?

MR PEACOCK: Actually interesting you say that because it did remind me of one of the points I wanted to mention, but I will answer your part first. In terms of having a registration, yes, there are people who have different qualifications, but this point in time anyone who walks in off the street can claim to be a counsellor because it is not regulated. As a result that's very

detrimental to not just the profession but anyone who might be seeking help who goes to someone who's not qualified.

I myself am a member of the Australian Counselling Association, so I can see exactly where concern would lie if you're going to someone who has gone through all of the education for it, because then we're (indistinct) due diligence onto the client who's seeking help who might not be thinking what do I need to do, how do I check this person.

One of the things that I did want to mention earlier was about rural areas where help might be needed more. If we enable an entire extra profession such as the counsellors to be more of assistance to people if there are any incentives or what not we would bolster the numbers of professionals in those areas. So I think that would also be a great help.

PROF WHITEFORD: Thank you.

PROF KING: Thank you very much.

MR PEACOCK: Thanks.

PROF KING: Next Ron Spielman. Thanks, Ron, and if you again can state your name, if you're representing an organisation the organisation and any opening remarks that you would like to make for the transcript.

DR SPIELMAN: I'm Dr Ron Spielman, and I'm not representing any organisation, although I've listened to the presentation by the college yesterday and I endorse everything that was said, but I'm going to hope to offer perspective from a clinician who's worked (indistinct) with individuals.

My hope in appearing before this hearing is to speak from the perspective of a now retired psychiatrist with some 40 years of clinical experience, and a psychotherapist and psychoanalyst.

My own clinical career developed from running a therapeutic community-based on group therapy principles through a few years as a director of drug and alcohol services for a population of approximately one million, to recognising that in none of these was I sufficiently well trained to understand the complexities of the underlying severe personality disorders which my patients were suffering.

Now, not every mental health clinician can have the privilege of this intense training, but I do consider that the mental health services need to assure greater competence in understanding and managing complex mental disorders that exist at present. In the course of this experience I came to understand that severe personality disorder has a mortality rate of at least 10 per cent. Severe personality disorder could present as any of the so-called mental illnesses through anxiety, depression and psychotic symptoms. Too early prescription of psychoactive medications risks driving the underlying issues even more deeply underground only to reappear repeatedly on later occasions. Any condition in physical medicine with such a mortality rate would attract far more attention and research funding than does this most lethal of psychiatric diagnoses.

I would like now to express some points from the vantage point of my own decades of clinical experience. I commend the Productivity Commission on the amount of thought and effort which has resulted in the draft paper. On reading the draft report my concern was that economic considerations, understandably in this instance, dominate considerations of the development and maintenance of mental health in individuals. A capacity for work is indeed a pillar of mental health, but so too are a capacity to love and to play. These three capacities contribute to a balanced personality. The current mental health system does not provide for adequate in-depth assessment of individuals and families who present to the system in a wide variety of manners and to a wide variety of service facilities.

Best attainable interventions at first presentation will save considerable future costs to individuals, their families and to societies as the result of development of chronic conditions. This requires the optimal training of all mental health professionals, and importantly their continued support by senior clinicians, who are too often lost to the public sector mental health services. Ways must be found to retain the experience gained by a long career in mental health services in the interests of staff morale in a highly stressful field of work. We have had an example of that this morning, I commend Jeni on her presentation and illustrating what it's like to be at the coalface. How important it would be to have the help and support of a consultant who can help the younger clinicians through these crises.

Mental health clinicians put themselves on the line in working with highly distressed and highly disturbed patients. All of us in the mental health services have our own issues, as do we all, and so need and deserve mentorship and supervision from senior experienced colleagues when such issues are activated by working with highly troubled patients.

The regrettable statistics outlined in the report in regard to suicide are the tip of the iceberg of the failure to adequately address the considerable levels of psychic distress in our community. The importance of severe personality disorder has contributed to most of the main economic drains incurred in the mental health field. For instance suicide, drug and alcohol dependence, eating disorders, domestic violence, child abuse and neglect and so on is vastly underestimated in our society. A heightened awareness of this important fact alone would focus policy development on issues underlying the most costly effects of mental ill health, and inform more costive effects at primary intervention.

Finally, an adequate understanding of the psychodynamic principles of infant, child and adolescent development, together with an appreciation of family dynamics underpins all aspects of management of mental health issues and their potential prevention. All mental health clinicians should be as competent as possible in this regard.

PROF KING: Thank you. Just a couple of questions to start off from me. So one of the things that is almost coming out as a topic this morning, I'm not sure how much of this morning you've been in the room, but a number of the presentations this morning have suggested that perhaps medication occurs too early, that there's too much of a churn them through and medicate them type of culture, that other alternatives need to be considered, non-pharmacological alternatives need to be considered, at least equally at the same time or potentially before medication, and you touched on it as well. So I'd like your views on it.

DR SPIELMAN: I have done more than touched though. Absolutely right. It was illustrated here this morning, the two individual cases that presented their own unfortunate encounters with the health services, and Jeni's excellent presentation as well shows that there is much underlying, and the rush to medication is partly due to - Jeni said there are too many incentives to write prescriptions and go and have brief consultations, but there's also a reluctance to touch on the deep distress and psychic pain that people are presenting. It's much easier to write a script than to take time to listen, and I think in both of the presentations here this morning where individuals presented their own distress you get a taste of complexity.

You are sitting there on behalf of the Productivity Commission, imagine if you were a clinician and had to deal with this in your consulting room. It would take more than one consultation, it would take several to get to the bottom of what is really underlying the distress of these individuals, and perchance I have just heard two and on a day to day basis this is what the health services are encountering. All tragedies that we hear in the newspapers of suicide, domestic violence, goodness knows what, there's always been an opportunity to do a more in-depth assessment and evaluation long before the tragedy hits the fan so to speak.

PROF KING: So in that situation incentives are something that we can deal with, although a movement away from ten minute GP medicine may be revolutionary, but we can't necessarily make - you can't change people's willingness as a clinician to sort of say, well I don't want to hear that story, it's easier to prescribe. Do you have any suggestions for practical recommendations that we could make to try and help avoid the overmedication. I understand the incentive side, but anything else?

MR PEACOCK: I've (indistinct words) to run the health services.

PROF KING: There's a chance.

MR PEACOCK: What one must do is train people to listen better, and sadly most of the trainings don't do this as well as they could. I've had a lot of high level training, some of which I paid for myself, but the point is it's being supported by peer groups and it's being supported by senior clinicians all the way. I'm now one of those senior clinicians, albeit retired. So I do think you can change people's willingness to listen as long as they're adequately trained and adequately supported and they need to have a venue to go to, a peer group for example, to talk about their difficult encounters and share experiences with peers, and this is time consuming and costly in itself, but if we're looking for a genuine solution to this serious problem then we've got to look to more time consuming and costly staff intensive methods and put less pressure on service delivery and throughput. That's just a brief answer to a very serious question.

PROF KING: I understand. Thank you.

PROF WHITEFORD: Thanks very much. A quick question related to one of the recommendations that has come up this morning, the issue about trying to intervene as early as possible to especially I guess deal with what later may become a personality disorder. One of the recommendations in the report has been to include a socially emotional wellbeing check we've called it at the time that GPs or us do the 3 year old health check, physical health check. Obviously that's a bit of a blunt instrument in some respects, but any comments you'd make

about the intent of that recommendation to try and not wait until there are clinical symptoms emerging, but trying to deal with the early issue which you did mention that might be causally related to a trajectory which is going to result in development of a mental illness later in life?

DR SPIELMAN: I think it's commendable, and the check list idea is not something that I have much faith in, but at least it's focusing on early infant development. I've spoken to kindergarten teachers who say that they can pick the children in their classes whose families are in difficulties. If we could find some way of offering services to the kids that those people identify - it's a family dynamic problem. I'm not trying to allocate blame, but when kids are in trouble it's because the family is in trouble, and the parents are already beyond primary intervention, they need secondary or tertiary intervention. But anything that's going to focus on the kids has got to be worth doing and spending a lot of time fine-tuning it.

My last point about family dynamics and depreciation of development it's got to be part of training not only mental health professionals, but also kindergarten teachers and school teachers, because kids who are in difficulties will demonstrate it at school, and that's one place of picking them up, and of course in general practice and pharmacies, and it's a daunting task. I don't have any ready solutions, but I've appended to my submission 18 a proposal that I wrote years ago for what I call a psychodynamic consultancy panel where each state health system should have available to them a group of clinicians trained as I have been trained in-depth and willing and able to deal with complexity to help them work through some of the aspects of programs that they're wanting to develop. I mean sadly I'm retired, but I really would like to still feed back to the system what's taken me 40 years to learn, and I still think I'm young enough in that sense. So we need to tap a lot of the experience that has been gleaned. It's not as if we need knew methods, we need to develop methods that are known to work in a long term psychotherapy field which means involvement at depth and at length.

PROF WHITEFORD: Thank you very much.

PROF KING: Thank you.

DR SPIELMAN: I haven't had the opportunity to say that in public before.

PROF KING: Thank you. Scarlett Franks, and if you could state your name, if you are representing an organisation the organisation and any opening comments you would like to make for the transcript.

MS FRANKS: My name is Scarlett Franks, I'm a 26 year old dissociative survivor of complex trauma, which is to say that I am living with a legacy of disempowerment through child abuse and neglect, domestic abuse and coercive control, sexual and domestic violence, as well as the betrayal of the psychiatric, criminal justice, child protection, welfare, public housing, NDIS, victim services systems, which prolonged my disempowerment.

I am here today because I'm really excited about the Commission, but I was really disturbed to see that in 118 pages of the overview the word 'trauma' appeared three times, and I urge the Commission to follow the United Nations in their declaration that mental ill health is about power imbalances, not chemical imbalances.

The Blue Knot Foundation, the National Centre of Excellence for Complex Trauma estimates that 1 in 4 Australians are living with the legacy of childhood trauma, and that this kind of history is the single most significant predictor of contact with the mental health system. I encourage the Commission to look at Blue Knot's submission to this inquiry.

We have a paradox in this country when it comes to complex trauma. High prevalence on the one hand and yet scarce recognition, awareness and allocation of resources, and as a result many people are inappropriately labelled with things like bipolar disorder and treatment resistant depression, disorders of a psychosis spectrum and the so-called personality disorders.

The lack of recognition and evidence-based intervention into complex trauma set me up four years of re-traumatisation. I urge the Commission to look out for a forthcoming report based on a two year ANROWS funded study by Salter and Conroy and colleagues at WSU and UNSW, which looks at Australian women's experiences of complex trauma, and what their broad finding was that trauma is indeed marginalised in our country, and that treatment is skewed towards men's experiences of trauma, despite the fact that PTSD and complex trauma are more common among women.

A recent study by Dr Marianne Cape of UNE and her colleagues found that dissociative disorders are about as prevalent as mood disorders like depression, about 11.4 per cent of the population, which matches on to rates of multiple childhood traumatic experience at about 12 per cent, and yet despite this prevalence there is only one inpatient program for dissociation in this country at Belmont in Brisbane. This issue is almost entirely relegated to the private system, which makes it very inaccessible to the people who need it most.

So my recommendations are as follows: firstly, that housing and financial security are fundamental to mental wellbeing and ought to be the foundation of any Federal suicide prevention policy. It was not until I finally got victims compensation and the DSP nearly six years after the rape that led to my PTSD diagnosis that I was able to do anything more than crisis management in therapy. All nine of my suicide attempts and all of my involuntary hospitalisations occurred during this period of insecurity and debt. I urge the Commission to recommend raising Newstart and the DSP and to abolish the deliberate bureaucratic barriers to these entitlements.

Secondly I urge the Commission to consider as we have just heard the marginalisation of psychodynamic therapies in Australia and the impact this has on clinicians and clients. As a nation we have overinvested in the techno centric trifecta, drugs, CBT and apps. All of these tools can be of some use to people managing their mental ill health, but when we rely solely on cognitive behavioural interventions we leave survivors feeling irreparably damaged when these modalities invariably fail to make inroads in their underlying attachment wounds and do little to improve their safety and wellbeing.

As (indistinct) Koslow testified yesterday it is uniquely difficult to train as a trauma therapist in this country and very difficult to make a living. Complex trauma is relational and is healed in relationship, but rather than giving survivors the opportunity to cultivate attuned relationships with an appropriately trained therapist we are condemning them to a revolving door of psychiatric admissions.

Thirdly I want to stress to the Commission that the biomedical model sometimes does more harm than good. As others have testified we ought to think about moving away from models that individualise mental distress, altered states and troubled behaviour, and instead move towards critical and peer led models and consider alternatives to prevailing diagnostic systems like the power threatening in-frame work developed in the UK and endorsed by Beunot. This will force us to start treating child abuse and neglect, domestic violence and coercive control, sexual exploitation and violence, ongoing colonial violence and austerity as the public health crises that they are, and we must invest in prevention and response across all sectors.

Finally I would echo the testimony given yesterday by Irene Gallagher for Beam that co-consumer - consumer co-design, co-production and leadership must be the foundation of any policy making proposed by the Commission, and this includes the funding, the training and the work of consumer researchers such as myself so that it is more than a tokenistic advisory board.

Finally I'd just like to share one quick thing about my experience with suicide and recovery that I think will highlight what I've said. So in one of my favourite survivor memoirs by Susanna Kason, she wrote that suicide is more complicated than wanting to die. It is about wanting to exile a part or parts of yourself, the parts of yourself that hold terrifying sensory fragments from the past and are stuck, unable to metabolise the rage, fear and collapse they bear, the parts of you that carry shame and the parts of you exhausted from carrying the shame, intense muscle and lockjaw.

I recently celebrated three years without a suicide attempt and this ten year personal best would not have been possible without the therapeutic relationships that have supported me to embrace these young traumatised parts of myself, parts that like many people I tried for decades to exile to unconsciousness through cutting, through starvation, through suicide. Attuned Relationships allowed me to greet these parts of myself gently and with curiosity so that I can find out what their needs are and learn to soothe them. It is through Attuned Relationships that I have been able to experiment with new ways of relating to myself as a safe reliable person I needed when I was younger. My recovery has been about learning to return to my body after having to vacate it for so many years, and about learning to be soothed so that I don't have to try and exile the parts of myself in need of soothing, and so they don't need to intrude upon me so dramatically and destructively, but I could only begin this recovery when I had stability and when I finally got trauma specific affordable psychotherapy, something we woefully lack in this country.

PROF KING: Thank you. Where did you eventually get the relevant trauma oriented psychodynamic therapy, how did that become available to you?

MS FRANKS: After the seventh suicide attempt I made it to the top of the triage for the peers, the Early Intervention Recovery Service for Youth out of Cumberland Hospital, and it was through that that I got onto a two year wait list for the fantastic Westmead psychotherapy program, which provided two years of twice a week conversational model therapies specifically designed for people with structural disassociation.

PROF KING: Thank you.

MS ABRAMSON: Thank you very much for coming today to speak with us, and it's obviously a courageous thing to do. So thank you for that. Following up a bit from Commissioner King I'm just interested - we have got a lot of recommendations around the school system and early intervention, and what would have made a difference at an early stage in the issues you had to deal with?

MS FRANKS: Sure. What would have been a difference would have been trauma literacy and a trauma informed school culture. Yes, I agree with the previous testimony that check lists and psychometric testing isn't always that fruitful, but I was often sent to a school counsellor as early - I was sent to the school counsellor in preschool because I was tearing my hair out at the age of 3, but when I was sent in primary school to the school counsellor for some kind of disturbing behaviour they almost always said, right, we're going to call your parents, there's something going on at home, which only exacerbated the violence at home.

PROF KING: Thanks for coming and being prepared to take us through that. I guess for us it's also good to hear someone who's managed to get through, well enough to sit and tell a story as well as you just did. I guess going back to the question I asked Dr Spielman is clearly the issue is - it's great that you got the treatment you did when you did, but you should have got something a lot earlier, in fact you should have got something a lot earlier. So coming back to the question about, do we screen every, you know, kindergarten teacher in Australia because they're the best to pick it up, or do we try and screen every 3 year old because they go to a GP for a check, and you could do that - it has to be a population level screen and so you're down to some standardised instrument which have all the criticisms that we know about trying to standardise it, and maybe you don't have the answer to this, but you were identified by somebody when you were very young as a young child that was in difficulties, and yet nothing seemed to have been done apart from tell your parents that you were a difficult child or something, which made no difference in your - - -

PROF WHITEFORD: Made it worse.

PROF KING: It made it worse. How could we intervene earlier, so maybe not at 3, but at 5 or 7 or before it became clear that you had a diagnosis and were referred to some sort of mental health - - -

MS FRANKS: Yes. I don't have the answer, but I know that there's a lot of great literature, especially from the United States about establishing whole of school trauma informed systems, and that's been experimented with to great effect in some places, and that is sort of more informal, the cultural version of just testing and screening everyone. The other thing I would say is that the marginalisation of trauma literacy in this country is there's kind of epistemic injustice against the survivors themselves, because when survivors get a bit of psycho education about the neurobiology of trauma, about attachment and things like that they are then able to - and I can only speak for myself, but I am thinking of all my closest friends that I all met in therapy or hospital - that, you know, I didn't start receiving the help I needed until the age of 24, but I had been fighting for it since I was 14, because from the very moment I learned a little bit about trauma suddenly I made sense and everything that I was experiencing and everything that I had been through wasn't delusional or irrational or crazy, it makes sense, I'm living with these adaptations.

So I think while the ultimate answer is prevention of the kinds of social injustices that create so much complex mental ill health, I think in the meantime becoming - if we became more trauma literate as a country, and I want to specify that we can't call everything trauma, we need to - we can't, you know, make it devoid of meaning, but we need to be specific about what we mean by trauma, but if we changed a conversation in the country from sort of awareness and medicalising very common experiences of distress then I think perhaps both teachers and the people with a duty of care to these young people, and the young people themselves, would be better able to advocate for what they need.

PROF WHITEFORD: Thank you very much.

PROF KING: Thank you very much. Perhaps if we take a break for lunch now. So 35 minutes or so and we will recommence at 1.20. So thank you.

LUNCHEON ADJOURNMENT

RESUMED

PROF KING: Let me restart after the luncheon break. Karen, if you could come down and state your name, any organisation you represent if you are representing one and any opening comments that you would like for the transcript - and I should have checked, transcript's ready? Streaming is ready? All right, thank you.

DR SPIELMAN: Thank you very much. I'd just like to acknowledge the traditional owners of the land on which we meet and acknowledge people here with lived experience, their families and carers and respected health professionals and service providers and thank you to the Commission for your work and for the opportunity to comment on it.

My name is Karen Spielman. I'm a GP and I have about 20 years' experience in normal general practice but I have a special interest in mental health in adolescents, in young people, and specifically I do a lot of work with people with chronic complex medical conditions and mental health issues including eating disorders and trauma. I've also established a general practice as headspace, Bondi Junction, in the last four to five years but I would like to stress that I'm here as an individual despite my associations with headspace and as well as being a member of the RACGP and an organisation called ASPM which is the Australian Society for Psychological Medicine.

I felt compelled to appear today as my every day work involves many of the issues which you raise in your report. I'm very grateful for your work in examining the limitations of the current system and your comprehensive attempts to explore the alternatives and I'm very aware that there's no easy answer to the very complex situations and conditions that we're dealing with. I wanted to speak as a frontline clinician rather than a manager or an administrator and I wanted to just restrict my comments to a few issues.

Regarding headspace I know that you've had other people from headspace, their appearances

yesterday, and so I'll keep my comments brief but I have been aware of this concept since it was raised probably about 12 years ago and, as I've said, been involved in the establishment of my local centre at Bondi Junction. It's a wildly popular centre in a very well resourced area which shows that it's an acceptable and very well utilised service by young people and I think that the benefit of the headspace model is its excellent responsiveness to local community needs with its local consortium partnerships and the federally funded components making a very, very good partnership which leads to very specific local responses.

I understand that it's a very expensive model but I believe that it's accessing young people who would not otherwise be receiving good services because it's very acceptable and recognised by young people. I feel that the comments in your report with propose more conditions on the funding feels very frustrating and counterproductive to the delivery of very good services. The statistics show that young people love the service and certainly my experience at Bondi Junction supports that and we feel that they come back often and they get better and that this is an incredibly positive thing in this incredibly vulnerable age group and I feel that this service should be supported and enhanced.

I think that the stepped care model works very well there but I believe that we're seeing many more complex young people than the model has been set up for which is more early intervention and that that may go somewhere to explaining why the data isn't as impressive as it feels like it should be. We talk about the missing middle of young people with more complex chronic conditions and I think that the centre is not well enough resourced to deal with these young people. I do believe that GPs are very well placed to work in centres like headspace and that we're well placed to enhance the management of mental and physical wellbeing for young people and I have been working locally with the centre and with the national office to try and encourage better structures and support for GPs in headspace and it would be lovely to have that supported at a higher level as well.

Regarding GPs I believe that many very GPs are very well trained and well placed to management of health issues but at varied levels depending on their experience and their context. I do support GPs with specialist training and experience being recognised and resourced in order to assess, diagnose, refer and in appropriate cases deliver treatment and for GPs also to be co-located in other services to enhance the management of complexity in multidisciplinary settings such as headspace.

I'm very aware of the limitations of the system including mental health care plans and very varied accessibility of ongoing psychological and psychiatric support. I think there's a gap between the Better Access funded services which are quite limited and people who are more highly at risk that may need more intensive care. Especially care coordination there are gaps between providers, financial barriers as we've heard can be enormous and difficult to overcome, community mental health services can have quite limited referral criteria and as GPs that can be frustrating and difficult to access the plans and psychiatrists, as we've heard, can be very difficult to access, psychologists can be too expensive and the services like PHN provided services can also be very limited depending on the area and this is inner city Sydney so I can't imagine how difficult it is in regional and remote areas.

I think the issues that the current Medicare system does not support long appointments and this is extremely counterproductive for mental health. Short appointments, which are more

remunerated, mean that thorough assessments cannot be done, treatment can be appropriate targeted and services are misused. I think one of the most important things I do is match my patient to the right therapist and that takes a lot of time and particularly with high risk conditions it's important to follow-up and to take a lot of time to listen and understand the patient before making appropriate recommendations for care. So, yes, part of that might be recognising GPs who are more able to do this and supporting GPs to coordinate and communicate with multidisciplinary teams.

And just briefly regarding mental health care plans which I think it was very exciting when they came in but it's been an interesting thing to watch. I do think that it should be reviewed and the system could be done better. I think the plans themselves could be improved and the number of sessions and the way that people make referrals could be done differently as well. It's very challenging to support more complex patients who require services with only ten sessions.

I know you've made some comments about combined care plants which I think is an interesting idea and something which could work towards supporting collaborative care. I'm also very aware of the new numbers for eating disorder management and I think that's a very good model. Again it would be very interesting to what how it goes and I'd be keen to see that happen and also to maybe consider if there was something similar that could be for either diagnoses and for more moderate or complex comorbidity. I think I'll leave it there for your comments, thank you.

PROF KING: Thank you. Let me start off and then I'll pass it over to my colleagues. I suspect we have similar issues or questions that we want to raise but let me start off with headspace and it's great to hear how well it's working in Bondi. But do you think that the headspace model is an appropriate model everywhere in Australia so in all locations or in all geographic locations, so I'll ask that first.

DR SPIELMAN: Yes, absolutely, because I think each location is quite unique and it's part of how it's structured that each location responds to the specific need of its community and that's a very, very big positive with the model. I have been involved in headspace national and I have been to national conferences and I have spoken to different centres and I've been an advocate for GPs within the centres and I always thought Bondi Junction was absolutely wonderful, magnificent, and when I turned up to the national conference last year there were about another 100 wonderful anaesthetist centres but they're all unique and they all respond to who's part of the consortium, what the particular needs are, what the community is made up of and I think it's a terrific model.

PROF KING: Yes, can I understand that a bit better because my understanding is that headspace is a franchise-type model so talking with the national office my understanding is that they actually put constraints, very significant constraints, about what headspace can offer in different geographic locations but you're seeming to say the opposite which is that there's a whole lot of flexibility.

DR SPIELMAN: No, it's not the opposite, it works together so there's a - it's called hMIF, the headspace Model Integrity Framework, which gives constraints to the way services are delivered, the way assessments are done and the kinds of services and the kinds of people who

make up the service but each centre is able to enhance or work that into the community so the brand is very recognisable to one people. Like, one of my favourite stories is a patient who drove passed the centre, saw the sign, pulled in, was actually suicidal, came in to see me and, you know, got through the front desk, got through the first assessment and we were able to provide an immediate service which down the track she was able to say it, hopefully, made a huge difference certainly in the time that I was part of her care. I thought that was a brilliant example and she wouldn't have done that if it was a hospital or general practice, it was the recognition of the brand.

PROF KING: If the brand.

DR SPIELMAN: So that's something that's very standardised.

PROF KING: So given the benefits that you've mentioned for headspace, it is funded in a very unusual way in that it is essentially central funded by the federal government formally through PHNs but PHNs have no discretion on whether or not they set up a headspace in their region.

DR SPIELMAN: Yes.

PROF KING: I mean, given the regional benefits and the flexibility that you've discussed, would we want a situation where we say, 'Look, every PHN if it wanted to have a headspace' but equally if they don't think a headspace is appropriate for their region they shouldn't be required to have one. Is that a reasonable approach or not because at the moment some PHNs are required to have them?

DR SPIELMAN: That's an interesting point. I've worked in general practice in inner city Sydney for about 20 years in a normal practice but I've worked in many different settings in my youth health expertise and so my journey has been trying to understand how young people best access primary care and there is no one size fits all so some of my patients at my practice will see me there, others wouldn't set foot in headspace but the ones at headspace wouldn't set foot in the normal general practice or they're seeing a different model of GP and getting a different kind of care which isn't meeting their needs at the time because it's not youth friendly practice so headspace facilitates youth friendly practice in a way that Medicare funded direct services do not and we're missing in general practice a very highly vulnerable cohort and particularly for young people the WHA talks about the second chance in the second decade and we've spoken about early intervention which is clearly the way to go and, you know, economically where you put your money but we do have a second chance for young people when different issues do come to the fore to have another go at - well, not early intervention but early intervention for the young people to - - -

PROF KING: Early in the course of illness, yes.

DR SPIELMAN: Yes. I can't imagine a situation where a community wouldn't want to (indistinct words) but I take your point.

PROF KING: Okay. Sorry, Julie.

PROF WHITEFORD: The GP mental health care plans, obviously they cannot cause some criticism in some respects that they're not serving the purpose they were designed to serve in some mental health cases so can you give us your comments about: (1) whether we should retain the plans?; (2) if we do, how should they be different to deal with some of the issues that have been raised and also, I guess, your view about what would work for you if you had to have a way of referring, you know, patients on to other providers?

DR SPIELMAN: Again I'd like to stress that I'm speaking as an individual for this. I think that there are many people who know when they need some help and I think that for some levels of care a referral like a mental health care plan is not necessary and either maybe a small number of sessions could be accessible by people without a referral for a normal GP referral just like we'd refer to a cardiologist or a gastroenterologist to prescribe a short course of treatment or a taster. I think that mental health care plans for - in the way that they're used largely in my experience and in my experience with my colleagues who are psychologists, they can be very well done but they're often not and the way that I've conceptualised doing the eating disorders care plans, I think it's just a little - it seems to work a little bit better. I mean, that's an area that I have a bit more experience that it kind of made it flow a little bit better in terms of making a diagnosis and using some other criteria and making an assessment and writing to the therapist and asking for coordinated care, I think that works well for maybe moderate conditions and I'm aware that it's not initially set up for moderate conditions but maybe having more sessions for more complex condition, more severe depression or anxiety or complicated presentations which require longer sessions would make it a more meaningful process rather than the earlier kind of stepped care.

PROF WHITEFORD: So the draft report does recommend an increase in normal sessions.

DR SPIELMAN: Yes.

PROF WHITEFORD: (Indistinct words) try and get rid of this issue of, you know, when (indistinct words).

DR SPIELMAN: Yes.

PROF WHITEFORD: When the session count starts and finishes.

DR SPIELMAN: Yes.

PROF WHITEFORD: So to paraphrase what they're saying: for some referrals (indistinct words) letter as exists for (indistinct) specialists could apply for individuals with more complex needs, a mental health care plan might be more appropriate.

DR SPIELMAN: Yes.

PROF WHITEFORD: Is that a - - -

DR SPIELMAN: I think so.

PROF WHITEFORD: Okay.

DR SPIELMAN: And as a GP if you know your patient and their family well then one of the best gifts that you can give them, one of the best interventions you can make, is to refer to a therapist that's a match. I often talk like it's matchmaking and I don't - that's a skill and then experience knowing who's around.

PROF WHITEFORD: And I guess the information that you put in that mental health care plan for individuals with more complex needs could be in a referral letter (indistinct words) send to the, you know, psychiatrist or neurologist.

DR SPIELMAN: Yes, yes.

PROF WHITEFORD: But whether creating a mental health care plan and a structure of it would be more useful for general practitioners who may have less of an interest in mental health than you do, would be inappropriate do you think, or?

DR SPIELMAN: I don't know.

PROF WHITEFORD: You don't know.

DR SPIELMAN: I don't know. I think it would require a lot of thought and input from people in different situations, yes.

PROF WHITEFORD: One more comment or question really. Do you refer to individuals (indistinct words) to online treatments?

DR SPIELMAN: Yes.

PROF WHITEFORD: And if you do, can you just walk us through how you'd choose that over, you know, a referral to a face to face psychologist?

DR SPIELMAN: I don't often choose it over referral to face to face psychologists. I'll often offer it in an initial assessment as something that can be accessed whilst we're working things out or whilst they're waiting for treatment. I think it's very useful as a tool. It doesn't have to be just people with early disorders who - or conditions that access it. I think it can be useful as many different parts of patient's experiences. There are some that are better than others and I know that there are people who put a lot of thought into how to collate that information and how to use that in general practice. So I think it can be used as an adjunct. I don't often get a lot of feedback from my patients about whether they found it useful. Things vary from time to time, people find different things useful. I don't think there's a one size fits all. I've been involved in some trials of some online therapy for young people and I'm not aware of the outcomes yet but I found it quite difficult, so.

PROF WHITEFORD: So you don't get any feedback from the online providers of the internet based therapies?

DR SPIELMAN: Occasionally. I mean, not a lot of - I mean, there's some that do do that but I haven't found that particularly - it hasn't happened all that often.

PROF WHITEFORD: Okay.

DR SPIELMAN: I'm not sure why, whether they're not using or whether (indistinct words) feedback.

PROF WHITEFORD: Yes, look, we are told that (indistinct words) information.

DR SPIELMAN: Yes.

PROF WHITEFORD: So I guess could explain (indistinct words).

DR SPIELMAN: Yes.

MS ABRAMSON: Could I just ask you about the mental health care plans. So in lots of other areas you provide a very detailed letter to the referring - to the specialist.

DR SPIELMAN: Yes.

MS ABRAMSON: So why would you prefer to write the mental health care plan whereas if something was going for, I don't know, advanced diabetes you might say to the endocrinologist just a bit of the clinical stuff and leave it to them to manage?

DR SPIELMAN: So why would you use a mental health care plan?

MS ABRAMSON: Yes.

DR SPIELMAN: Because that's mandated, because we have to. That's what we're told to you. We're told to fill in the boxes.

MS ABRAMSON: But if you had a choice would you prefer just to write a normal referring letter?

DR SPIELMAN: Yes.

MS ABRAMSON: Thank you.

DR SPIELMAN: And I'd like to be paid properly for my time. So that does access - you know, I can understand why it's used and - but, yes, absolutely.

MS ABRAMSON: Just on the online referrals that we were just talking about. Do you think that your clinical practice might change if you were able to get like evaluations that said for a certain (indistinct words) patients it was highly successful so it's really a question about outcomes and not actually seeing the data about the programs?

DR SPIELMAN: I'm fairly informed about that so I do know that they're supposed to be successful and I have a reasonable grasp of what kind of conditions respond to what sorts of things so I don't think - - -

MS ABRAMSON: That would change. No, thank you.

DR SPIELMAN: Thank you.

PROF KING: Thank you very much.

DR SPIELMAN: Thank you.

PROF WHITEFORD: Thank you very much.

DR SPIELMAN: No worries.

PROF KING: And how did I know my colleagues were going to follow-up on the mental health care plans.

MS ABRAMSON: (Indistinct words).

PROF KING: Carmel. Sorry, Peter, you're coming up as well. Thank you. If you could state your names, organisation that you are representing and any opening comments for the transcript.

MS TEBBUTT: Thank you. So my name is Carmel Tebbutt and I'm representing the Mental Health Coordinating Council of which I am CEO.

MR GIANFRANCESCO: And I'm Peter Gianfrancesco. I'm here as a board member of the HMCC but I'm also the state manager for Neami National which is a community managed organisation.

MS TEBBUTT: Thank you. So we do have some opening comments and then happy to answer questions. So I will broadly make the opening comments but Peter may chip in as we go through. So thank you for the opportunity to speak today. The Mental Health Coordinating Council is the peak body for community managed mental health organisations in New South Wales so we provide leadership, policy leadership (indistinct words) systemic change and we also build sector capacity through research. We're a registered training organisation so we provide support for our members in that way as well.

So what I wanted to do today was talk briefly about the community managed mental health sector, address three issues that we think are a priority that are covered in the report but we would like to talk about in a little bit more detail and that is the need for more subacute residential care, the CMO workforce and also the reforms relating to proposed roles and responsibilities or governance reforms.

We do want to commend the Productivity Commission for its very comprehensive report and also the consultative approach that's been taken to preparing the report. We put in a submission as did many other organisations and individuals for those who work on mental health the challenges are well known and I think there's a lot of hope and optimism that the Productivity Commission inquiry will underpin what has been described I guess as a once in a generation

reform opportunity' so I think there's a lot of hope and expectation.

There's a lot in the draft report that we agreed with particularly to focus on putting consumers at the centre recognising the social determinants of mental health and documenting the significant economic costs of mental illness. We are also pleased to see that the report acknowledges that there are significant gaps in terms of community based services and the need to provide better support and services for people in the missing middle.

We would like to see a stronger focus in the report on the role of the community managed or non-government mental health organisations in addressing this gap in support for people through the provision of psychosocial rehabilitation and support services that embody a trauma informed recovery oriented practice approach and they're essentially the services that our members provide. So they're things like accommodation support and outreach employment, education and recreation opportunities, family and carer support, self-help and peer support, counselling and clinical care in rehabilitation services and also information in advocacy.

Now, we know that the draft report refers to the role of psychosocial supports but it generally sees them as complimenting community based clinical services and while they very much do do that, they are much more than this. They are standalone services, they play a vital role in supporting recovery for people with enduring mental health conditions, they work with people over the longer term addressing more than just symptoms and they are often the key to people living well in the community.

Now, I know that you're familiar with the New South Wales program, the Housing and Accommodation Support Initiative because it is referenced in the report but we do I guess point to that as a great example of what well-funded psychosocial support services can do so HASI supports more than 1000 people a year to live independently, there's a skilled workforce that supports people with things like shopping and budgeting, joining social activities, getting to appointments, but also providing much more intense support for people with complex and coexisting needs to things like supported decision-making, managing self-care, skill building capacity, so it's much more than just a drop in service that's helping people socially engage and Peter could certainly talk in more detail about that if you wanted more information because Neami are a major HASI provider in New South Wales.

Now, I'm sure you're familiar that the program has been evaluated and the University of New South Wales evaluation demonstrated that there are significant benefits for people who participate in the program including a 24 per cent reduction in mental health-related hospital admissions following HASI supports and a 51 per cent reduction in ED presentations following two years of participation and an estimated \$30m in savings each year. Now, it is our view that while there's about 1000 people supported through the HASI program in New South Wales there are many more people who would benefit from such support and in fact we had KPMG do some work for us about 12 months ago and they estimate that there's probably about another 5000 people in New South Wales who would benefit from a HASI-type support - not necessarily full blown HASI but definitely those sorts of supports. So that's just an example I guess of some of the services that our members provide.

In turning to the three areas that I wanted to provide some specific comments on. First of all workforce: we can't develop/deliver the services that people need without the workforce to be

able to competently and capably deliver those services so it's critical. We support the broad thrust of the workforce recommendations in the report particularly the need for a national mental health workforce strategy but it must address the needs of the community managed mental health sector workforce strategy but it must address the needs of the community managed mental health sector workforce and we don't believe that that's adequately covered in the report and I'm sure you've heard this from other submissions as well but in New South Wales this workforce is estimated to be a quarter of the total mental health workforce so it's a significant workforce.

It's a workforce that's well trained and experienced in delivering supports to people with complex needs in the community, employing both Certificate IV and degree qualified staff with experience in working in partnership with clinical services so we are concerned that in the report there's little mention of the psychosocial support workforce outside the peer workforce and we very much support the recommendations with regards to the peer workforce but the workforce of our members is much broader than peer workers.

We have just undertaken a survey of our members in New South Wales to get a better understanding of what the New South Wales community managed mental health sector workforce looks like. Now, we're finalising that report at the moment but we'd be very happy to share it with you because - - -

MS ABRAMSON: We're very interested (indistinct words).

MS TEBBUTT: Yes, nothing's been done since 2010. This report is New South Wales specific, that's who our membership are, but nonetheless it's got some very interesting data about how many people work in the sector, what the qualifications look like, (indistinct words) between male/female workforce. Just under 50 per cent of the workforce are casual or on short term contracts so we will share that with you as part of our submission when we put it in before the end of January.

So the second area that I wanted to briefly mention is the recommendation around the need for more sub-acute residential care or step up/step down facilities so this is recommendation - I think it's 7.1 in the report. This is a particularly important recommendation for New South Wales because unlike other States we only have a handful of step up/step down facilities in New South Wales. We know there's strong evidence that this model of care provides both good outcomes for individuals but also enables better management of acute bed pressure and reduces demand for hospital admissions.

The step up/step down facilities that do exist in New South Wales are somewhat different to other States because they've largely been I guess organically driven by relationships between non-government organisations and LHDs but we believe the ones that do exist have developed some very good outcomes and Peter could talk a bit more about that because Neami run a few of those so I might hand over to Peter to talk a bit about that.

MR GIANFRANCESCO: Thanks, Carmel. Yes, Neami operates the step up/step down or sub-acute model in four states and it's fair to say that the models vary quite a lot from place to place and state to state but there are some fundamental similarities that are I think really important for the consumer journey and that is that whilst they do provide a step down function

for acute hospital beds which helps relieve the bed pressure and bed blocking over time most of them can demonstrate that the people using the service more typically step up and that's actually really important because that represents a way for a person to access comfortable, familiar support and treatment in a really early stage of their acute episode and our experience has certainly been that when we do that, when we make that easy for people, we have people getting treatment for acute mental illness much earlier on, they stay in the sub-acute for a much shorter period of time and generally they stay well for longer in between episodes and so these services should be seen as something more than just a way to manage bed pressure, they should be seen as a community based facility that really delivers early intervention in sort of acute treatment.

And I suppose the other point I would make is that there's some good evidence that shows that these types of services do reduce demand for inpatient admission, they do reduce people presenting at emergency department quite significantly and more importantly they are really helpful to people and they're very acceptable to people so people want to use them and a final point would be that if we look at the various models across the country they do represent a whole lot of ways in which the CMO sector can work with the clinical sector whether it's having embedded clinicians in the team, whether it's have embedded support workers in a clinical team or whether it's the CMO directly employing the clinical staff as is the case in some of our sites and they probably represent in my view best practice in terms of that clinical psychosocial collaboration. Thank you.

MS TEBBUTT: So to finish, the third area that we wanted to briefly touch on are the recommendations around governance, federal roles and responsibilities. We strongly support the recommendation for co-defining responsibilities through a national agreement, we agree that there's need for better data and public reporting on performance of the mental health service system. We strongly support the recommendation for five year contracts, that is something that would make an enormous difference for our members in terms of being able to plan services and deliver quality over the longer term. We're still consulting our members with regards to the Commission's recommendations about the renovate versus rebuild model so we will address that in our written submission.

We certainly support what the Commission is trying to achieve with that recommendation, the need to right incentives to ensure that the most effective care and support is delivered when and where someone needs it. I guess on first glance we do have some concern that the regional commissioning authorities would be challenging to establish and that accountability for who's responsible if they don't have the funds to deliver the services that a particular region needs would be difficult to address and also some concerns that in splitting off mental health service commissioning from the delivery of physical health services, that could impact on integrated care when someone actually is in hospital so they're some initial concerns but we definitely need something that drives the right incentives in the way services are funded.

With regards to the renovate model we did just want to put on the record I guess some comments about our current experiences with the current system with Primary Health Networks which is a relatively I guess new development in Australia so our members have worked very closely with the Primary Health Networks and developed good relations, no question about that. Many of our members are funded by Primary Health Networks through their commissioning of mental health services.

There are a couple of things that we would like to say that we think would help more effective working together or more effective collaborative relationships. Many community managed organisations have decades worth of service delivery and partnership experience that we feel Primary Health Networks could more effectively utilise than what they always do. Co-commissioning models work best where community managed organisations along with people with a lived experience, families and carers are involved in discussions upfront so that they can help identify the need, shape the response, develop the model and agree upon the outcome measures and we don't see that that happens as often as it should.

We also think that obviously one of the great strengths of the Primary Health Networks is that they can adapt what they do for their local community's needs but one of the downsides to that is there's a lack of consistency in the approaches they take to commissioning services so for community managed organisations that are working on a national level, they are often dealing with multiple Primary Health Networks, different KPIs, numerous outcome measures, different lengths of contracts, gaps between when contracts start and finish, overhead budget parameters that are different, so that has a real impact on organisations that are not necessarily funded to have those sort of compliance sense contract management staff so it would be good to find a way to get the benefits of regional service delivery and regional understanding but some consistency around some of that contracting so that there isn't this sort of duplication that impacts very much on our members. So we'll leave our comments there but happy to answer any questions.

PROF KING: Thank you very much. Let me kick it off. Peter, you were talking about the Neami facilities in the different states and really very interested in that role not just as the step down from hospital, which I think we probably emphasised in our report, but actually that step up role which has been pointed out to us by a couple of parties in the hearings so I'd like to understand a bit better about how an individual who recognises that their condition's deterioration, that they're likely to have a crisis or are in crisis, who do they actually access the facility? Can they self-refer, do they need to go through the clinician, how does it work to make sure that operates as that safety net?

MR GIANFRANCESCO: Yes, there's not one single answer to that unfortunately but if I give you an example of where I think it works really well would be in Broken Hill. So Broken Hill Sub-Acute Program is operated by Neami in partnership with the local health district and I guess it's a really good example of how the clinicians and the Neami staff work together to balance out it is of access so people can self-refer but everybody is subject to a shared assessment of need and priority so we don't do that in isolation from the clinicians who have been involved in supporting that person but typically time, and this is quite a mature step up/step down, it's been operating for nearly five years, you do always see quite a focus on step down at the start and in my opinion the better step up/step downs, and often they're the ones that are operated by the CMOs', you start to see a transition to more step up over time and that can really only happen if people can directly access and refer at that point in which they believe they need something.

So if someone was self-referring and the assessment was their needs would be better met by an inpatient admission then that can happen at that time as well and likewise for people being considered for admission to the psychiatric unit, those people self-referring or, you know,

presenting on a voluntary basis can be diverted straight into the step up/step down.

PROF KING: Okay, thank you for that.

MS ABRAMSON: Thank you and welcome back to the Commission. One of the things that are very well aware that we needed to move in that community mental health area, we've understood that, but we need a little bit of help to do it so the information that you're able to give us about the workforce is really important. We had the same conversation with the Australian Services yesterday because when our staff looked from the outside it was very hard, we couldn't see a system, we could see individual types of organisations so some support there would be very helpful.

So one thing I did want to ask was at the moment in our diagram we've got the clinical supports (indistinct words) the clinical being the pathway to the psychosocial, that was not actually our intention. We understand with psychosocial supports you could have someone has a low intensity in a clinical sense but very high in psychosocial so we're interested in your thoughts and happy for you to take it in notice about what type of criteria you would have for that because if you have a clinical diagnosis then, you know, you can get into certain services, certain government programs, but clearly there a range of people who just want to access the psychosocial supports and you did just speak then about self-referral so we're interested in your thoughts on that.

MR GIANFRANCESCO: Yes, so perhaps HASI is an example of that and again it does vary a little from place to place. HASI is very much geared towards the more complex end so typically people using HASI but not exclusively are going to require treatment at the same time as a focus on those psychosocial goals but it is possible that sometimes people will be receiving their treatment independently of the public health system and those people can be supported in exactly the same way just with a different set of relationships with those treating providers.

There is always a bit of a pressure in terms of ensuring that the HASI service is focused on those people who have I guess the greatest impact from their psychosocial disability and their illness and there are a whole lot of other programs that I guess are slowly disappearing or have disappeared in terms of things like Partners in Recovery and PHaMS that were probably much better geared towards easy access really targeted focused help and then people being able to move out of that system relatively quickly and I think there's a real missing piece there in our system now.

MS ABRAMSON: We'd really welcome some more thought from you on that because we know it's an area that we need to do some more work with, thank you.

PROF WHITEFORD: The question comes back to us several times about the way we describe psychosocial support service (indistinct words) way it's discussed seems to be things to different people depending on what we're talking about. So one way we try and I guess understand this to see whether the original work that was done around some sort of taxonomy of services has been progressed, I know that AIHW coordinated some work on that some time ago but it seems to have gone into abeyance. Do you have a view about a way of sort of describing those components that are essential making sure we capture their - they're not missing from some, you know, community service delivery around Australia?

MS TEBBUTT: Yes, so with regards to the taxonomy while there may be some disagreement around the edges essentially it exists and people have agreed to it so it seems to me that it's sensible to work with that and certainly we use those 18 categories in our workforce survey and we got feedback about what's being provided in New South Wales. There were a number of organisations that identified other services that they provide that they didn't feel were covered by the taxonomy so when you see the report you'll see that but essentially actually if you look at those services they probably did fit into one of the taxonomy categories, it's just people perhaps didn't see it that way.

I think it would be very helpful for the Commission to recommend that all states and territories participate in the National minimum data set for non-government mental health organisations because at the moment there's only two states that are collecting that data and it makes it difficult to tell the national story about what the CMO sector are delivering if we don't have national data. Now, there's some I guess again weaknesses in what would be collected because it would be largely output data but at least it's a start and we are working with the New South Wales Minister of Health to implement the NGOE in New South Wales and I think that we are making progress and it probably will hopefully have that implemented next year but it definitely is something that needs to be done across all states and territories.

But, you know, the taxonomy is a bit kind of - when you read it it doesn't properly convey really I guess what psychosocial support services do so Peter could probably talk more eloquently about something that resonates rather than a list of 18 fairly dry categories so I don't know if you want more on that but we wouldn't want to move away from the taxonomy.

MS ABRAMSON: As I said before we need some more assistance with this.

MR GIANFRANCESCO: Yes, and that probably is the tricky thing to understand that it goes beyond the structure of services to the values and practice that operation within and around recovery and hope and meaningfulness and, you know, you could have a psychosocial support service that was doing a whole lot of things that might be helpful but may not be leading towards a more meaningful contributing secure life so it goes beyond the definition of the service to the principles on which it operates.

PROF WHITEFORD: So have you got a view about what the resistance has been about adopting that taxonomy across the sector because is it about the fact that it's a dry list of 18 categories which - well, what's behind - what do we need to do to overcome this?

MS TEBBUTT: Yes, I can only speak for New South Wales. I don't think - we have undertaken two projects now to consult our members about their willingness to implement the National minimum data set and there's a great deal of support amongst community managed organisations to implement that in New South Wales. Yes, there's a little bit of concern about the data burden that it might impose on organisations but they're already collecting enormous amounts of data for the various contracts that they have with different organisations so I don't think there's resistance now, there may have been in the past but I don't think there's resistance now on the part of non-government organisations to participate, I think it's more just about making sure that both the Ministry and the organisations prioritise that amongst the myriad of other things that need attention, time and effort and - - -

MR ROSEN: Sorry, can I just (indistinct words).

PROF KING: Sorry, it's just impossible to do comments from the floor but if you would be interested in waiting just for a few minutes.

MS TEBBUTT: Yes, Tully Rosen did do some of the initial work - - -

PROF KING: Yes, I'll get him to join down but after a few seconds.

MS TEBBUTT: Okay. So, yes, I think that really now it's more about prioritising how that's going to happen so now in WA and Queensland they have a portal that organisations can directly use to submit their data through their health departments then on to AIHW and so we would like to see something like that in New South Wales and I think it's more just the logistic results in issue, I don't think there's any actual objection to participating in it.

PROF WHITEFORD: No, well that's good to hear.

PROF KING: All right, thank you. Just a final one and this is to take on notice, obviously very keen to get that report you're putting together on the workforce and obviously in further submissions really keen to hear any suggestions you have for recommendations relating to the psychosocial workforce that we can put to government so thank you.

PROF WHITEFORD: Thank you.

PROF KING: Thank you for that. And my apologies, would you like to - because it's on transcript you have to come down here and formally sign in as it were so if you can state your name, organisation and just your comments.

MR ROSEN: (Indistinct words).

PROF KING: Sorry, it's just to make sure we don't miss - - -

MR ROSEN: (Indistinct words) the only reason I'm trying to come in.

PROF KING: Not a problem.

MR ROSEN: My name is Tully Rosen, I'm an ex-employer for Mental Health Coordinating Council (indistinct words) this project would have been about ten years ago. I just want to give two bits of context to help you (indistinct words).

PROF KING: Please, yes.

MR ROSEN: Now, the development of the National Mental Health Data Set (indistinct words) establishments, that was developed at the same time and then parallel with the National Service Planning Framework so it aligns up nearly perfectly and was designed to do that and was also designed to be able to, once that was established, breakdown into a client level data

set and outcome level data set so all of that information is there in the reports but it is, you know, it's six to ten years old some of that.

The only other thing to know about the data set and the taxonomy is that that data set was initially based on the data systems of NGOs and not much has changed so it's definitely not the NGOs that are having any issue with that. What would happen every time that it would go to a national process, we'd have all the states together, it would be built up, the states realise they had to pay for it to get rolled out, it would disappear to really a lot of it came down to federal agreement that the states could never really get the resourcing to happen.

PROF KING: Okay. Sorry, just before you finish. Harvey, have you got - - -

PROF WHITEFORD: So if you just give us a little bit more history. So the NGOs were largely supportive of it.

MR ROSEN: Yes.

PROF WHITEFORD: (Indistinct words)?

MR ROSEN: The state and the federal data strategy and information strategy bureaucrats were fully supportive.

PROF WHITEFORD: Right.

MR ROSEN: It would just end up - even when the finances were earmarked usually in budgets at the state level to implement the data set it would never make it through and so generally what would happen is they'd sort of sign up to it and then at various committees they'd have to say, 'We'll do it when we can' and that is never good.

PROF WHITEFORD: So the fact that two states picked it up and the rest didn't were about, you know, the motivation to (indistinct words).

MR ROSEN: This is just my opinion and I know that you're heavily machinated and there was so much goodwill you wouldn't believe how all of the organisations, all the government agencies, that really there was no one trying to stand in the way there, it just didn't get through.

PROF WHITEFORD: So for a recommendation from the Commission, because obviously we're supportive of (indistinct words), then there's no barrier you can identify that should stop it from happening.

MR ROSEN: The only issue is the NDIS and likely the differing nature of the data requirements for the NDIS probably doesn't line up very well but again the taxonomy is mostly covering what the sector does plus extra - plus psychosocial plus the new sector.

PROF KING: Okay, thank you.

PROF WHITEFORD: Thank you.

PROF KING: And apologies for the formalities, it's just so that we make sure everything gets on transcript so thank you, Tully. Next Alicia Boyd.

MS BOYD: Sorry, can I just sit here.

PROF KING: Yes, sorry, if you could please sit and just give me a second. Thanks. And if you could state your name, if you are representing an organisation what the organisation is and any opening comments that you'd like to make.

MS BOYD: My name is Alicia Boyd. I am representing myself and my family's lived experience of mental health challenges and also acting as carers and representatives and advocates for someone with a severe mental health issue who's currently hospitalised (indistinct words) at the moment my sister, Nicola, and I guess my initial remarks are to thank you for taking the time to have these public hearings and to engage the public and interested organisations in contributing in this way and for carrying out the review which I feel is really crucial so thank you.

PROF KING: What particular issues have you, your family, found in the roles as carers, someone who you love who obviously has mental health issues, what's worked or hasn't worked I guess from your perspective?

MS BOYD: We've had some clinical psychiatrists and nursing staff and also psychosocial supports who have been really engaged in working collaboratively and really working with my mother, Ann Boyd, working with my sister, Nicola Boyd and she suffers from schizophrenia and she also has quite severe autism. I also struggle with these same two disorders but I'm in a very different place in terms of personal wellness and she sometimes isn't necessarily the best advocate for her in care.

So it's been a combination of having that patient centred approach but then also bringing in the family and her boyfriend and the other supports that allow the medical team or the care team or the psychosocial support team to understand perhaps the bigger picture of what's going on and what - because sometimes she'll misrepresent things or she'll be so unwell that she'll - like all she'll focus on is that the King of Jupiter is sending her love and she had to swim in the sea with her clothes on because he was going to take her to Jupiter and, you know, like it's really profoundly difficult but when she's well she's quite lucid so it's - but where we have teams of healthcare professionals who are not willing to take us on board in that process or want to be like really prescriptive in terms of her care, has to be like, you know, which we found we encounter or people who don't want to engage in the other supports.

So we've had quite a few psychiatrists who haven't wanted to even enter into discussion around psychosocial support and community support or assist us in anyway with that and that's been really, really very difficult and we've had a couple of psychiatrists who have really tried to actively shove my mother, Ann Boyd, out of the process and really kind of wield a bit more control around what goes on with her and it's led to some pretty disastrous results like - - -

MS ABRAMSON: Ms Boyd, can I just stop you for one moment. I'm making an assumption that you're comfortable and informed to talk on your sister's behalf.

MS BOYD: Yes, yes.

MS ABRAMSON: Thank you. And you've been very good just refraining from naming people. I'm sorry to interrupt you but it's live streamed so I just want to make sure you're comfortable.

MS BOYD: Yes, definitely, yes. And I feel - yes, there's - I think that interdisciplinary approach that also brings in the patient and the family and the other key, you know, members of her personal life into the equation because we've had the experience - like, we're not professionals, we've had the experience of witnessing her various cycles of wellness and unwellness over the last 20 years and unfortunately she's in a very bad place at the moment and it's partly been the culmination of she was given a medication she was quite allergic to and it was known to the psychiatrist, it was on her medical records but we were blocked for a short period out of being engaged in that process and so that's led to a pretty bad reaction.

She was experimentally taken off antipsychotic drugs for a while against our wishes, because she really doesn't want to take them at all and doesn't have the awareness that she needs to take them, or that she becomes really unstable and unwell without them.

So it's partly - for us it's a difficulty navigating the fact that she's very unwell and doesn't often act in her own interests, and the fact that health professionals that we're dealing with aren't always acting in a collaborative way with us, and even sort of necessarily noting the medical record and basic things like that.

PROF KING: The issues that you've raised, you found other carers and consumers raising similar issues, and they are issues that we are trying to think how best to address. So when your sister is in a good place, when she's stable, do you think there would be a possibility there that say she could make a care order, or a more legal term would be a Power of Attorney, but I'm not the lawyer, my colleague is - advanced care directive - that sort of - having access to something like that where she could say, 'Look, next time I'm in a bad place I want you guys to be involved in the conversations. I want you to have rights with regards to my treatment. I am now lucid, I can make that decision, but I know down the track I am not going to be in the situation', would that sort of thing where it then becomes a requirement on the treating teams to bring you into the conversation, would that help?

MS BOYD: I think it would help tremendously if she wanted to, if my sister wanted to go down that track and that was her consensual choice, and I think it is important that it is something that she - - -

PROF KING: Chooses.

MS BOYD: - - - she has, you know, an independent choice over, definitely.

PROF KING: Okay. Anything on this particular bit, or just - okay. Can I ask you about - your experience is with mental health that is cyclical in nature, and one of the things that we've grappled with in our draft report, and we need to do more work on as we move towards the final report, is that we seem to keep hitting government programs and services and so on, but aren't cyclical. I mean the most obvious is things like Disability Support Pensions, other

income supports which you're either on or you're off. Are you able to comment at all on - have you found that there is a lack of flexibility in health services or other services just recognising the fact that mental illness isn't just a constant, it's not like an amputee is an amputee - sorry, I'm not expressing myself very well, but - - -

MS BOYD: I think you've articulated yourself well. From my own lived experience I've had a lot of difficult at times of me accessing income support. I'm a professional conference organiser and I am often really quite capable and functional and producing some of the biggest events in Australia, but when I'm not - when I'm in a place where say my mental health has been affected by the scarcity of work in Australia it's a really kind of cyclical industry events. I've had a lot of trouble being able to access any kind of assistance, and I'm only really personally capable of getting the psychological support that I need and psychiatrist support that I need when I am earning well, because I have to pay for it out of my own pocket because - and I see a really good psychologist who's a transpersonal psychologist.

He's brilliant, he's really helped me over the last five years, and I'm starting to see a psychiatrist soon to see if maybe being on a mild antipsychotic might assist me to maintain wellness with my - particularly as an autistic person I'm very vulnerable to excessive bouts of stress. I kind of can collapse into a little bit of a mild psychotic state and I'm hopeful that that will help me to maintain my personal resilience.

I don't extend into these extreme states like my sister thankfully, but I think we've got the same, I guess, or a lot of the same kind of make-up, it's just more she's been through this semi-dysfunctional system in a different capacity to me. I've been able to make my own independent choices of who - where I'm getting the care, who I'm engaging with, whereas for her because she's been in this public system and she's been quite a lot more severe she hasn't had that freedom. So for me it's difficult, because at the times when I might really need the psychological aids the most I'm very often not able to pay for them.

PROF KING: Just one final one and then I will pass over to my colleagues. Can I ask you about stigma and discrimination, and if you face that and - have you got any thoughts about what we can recommend to government to try and reduce - preferably remove, but I'm not quite sure if we could ever remove the stigma and discrimination - but to at least reduce stigma and discrimination around mental health.

MS BOYD: I think that stigma is a (indistinct) social issue. It's a community awareness related issue. I think that it's something that most people would to some extent, and I'm ashamed to say I to a good extent hold around people with mental health disorders and it's something that I'm trying to work on personally in terms of my own mindfulness and my own personal growth around that and not using disabling language or derogatory language around mental health - you know, having a wellness focus towards myself when I'm well, you know, treating it as if it's a medical issue, which it is, and treating my autism as if it's a different neuro type at first, and when I'm compromised by it it's a bit of a disability, not treating, not pathologising myself about it, not down talking myself about it.

These stigmas I think are really prevalent in the community and they're very - it's difficult to navigate in the workplace. I find I tend to go better if I don't raise my autism in the workplace. I tend to have a much better go of it. I was experimentally trying to be quite open about my

disability for a while there and it hasn't really worked for me. I've tended to function a lot better and be treated with a lot more equal respect when I don't, and when I'm - you know, when I'm quite well and functional I don't really need to raise it. That's been something that I've noticed I think.

To change that attitude - I've seen a lot of really brilliant community awareness campaigns around a lot of the work that's been done by Beyond Blue has been really reducing stigma, Black Dog Institute, like just in terms of that community scale, and I think people with autism speaking up around their lived experiences and showing that we're not all always, you know, completely socially incapable, incapable of holding up regular jobs, you know, there's a broad range of people on the autism spectrum who are leading really quite functional lives. I've seen a lot of power in the self-advocacy movement, like autism self-advocacy, people speaking out about their own lived experiences and supporting one another, and that has been, I think, a really powerful way of reducing the stigma around basically empowering us to seek for ourselves.

PROF KING: Thank you.

MS ABRAMSON: First of all could I thank you for coming today and for sharing your feelings with us. I wanted to ask you a bit more about the workplace, because clearly you have been working. But it's not just the attitudes of people in the workplace, we're thinking through some really practical things that - you know, what type of things would make a difference for you in a workplace? Was it flexibility of being able to work some days and not other days, what type of things?

MS BOYD: For me the main things that have really contributed to the workplace being functional for me have been really simple things like having a healthy workplace culture around bullying and things like that. I've had a few workplaces where bullying has been really rife and it's really set me off, you know. I have a very low capacity for that. But I've had brilliant workplaces where we've had a little bit of organisational bullying, but the management has taken a really strong approach about it and we've worked on resolution of issues. You know, kind of like all of those bullying guides that you have to work when you get inducted into a workplace say that you should do very few organisations actually follow. That's been the biggest thing for me.

In terms of reasonable expectations for work flow and what my workload is expected to be, like expecting me to push myself, but not crazily unrealistic, and sometimes in my industry that is the case.

MS ABRAMSON: So it would be quite difficult in any industry because it's peaks and troughs.

MS BOYD: It can be a peak and trough related thing, but in a lot of organisations they really manage their work flow quite effectively and they're very logical about it. So they're not stretching themselves beyond their capacity, not expecting people on a routine to work beyond the usual 9 to 5 unless there's, you know, you can add on potentially two or three hours in a week quite comfortably, but I've worked in some organisations where 60, 70 hours a week was expected, you know, and I'd have like a 6 am meeting in the morning and then I'd have a 10

pm meeting in the evening, and particularly as I'm going on in my career and I want to keep producing larger scale events and working on things like that I'm finding contract-based work has been really helpful allowing me to work on project milestones, so taking a bit of space back from having to like potentially even working, you know, an eighth of the time on these kind of larger scale shows. So I'm able to earn fairly well and still perform.

Kind of unfortunately, but I've been making peace with it, a bit recently working on events that are a bit below my career level, but are still, you know, regular earners for the organisations that I'm working for has been helpful in the short term, but I'm not wanting to rest on that forever, you know what I mean. So another thing I'm looking to do in the next two to three years starting my own organisation and producing my own events on a small scale to start with and then, you know, tracking on from there. But at the moment, yes, it's just been really mindful constraints. I think the issues from my personal experience, and I can only really speak from my own personal experience and I guess like the experiences I've seen shared by other people with autism the big thing for me is just really understanding the human constraints, really understanding that the things that are - I don't personally think that people with autism are necessarily that different from most people, we're just a little bit more sensitive to the things that might be dysfunctional for other people as well.

So I mean if anyone is going to be forced on a regular basis to work for a 70 hour week or deals with things like organisational bullying you might be a bit more resilient to work, but it's going to have some kind of negative psychological impact, these kinds of things. So I don't think, and I know from my personal experience, most of the things haven't been things that - I don't believe they're unique to people with autism, these kinds of workplace stresses, it's just more creating - - -

MS ABRAMSON: (Indistinct) impact on you.

MS BOYD: Yes. So I think creating like just more health workplaces would solve a lot of the issues.

MS ABRAMSON: Thank you for that. Can I ask you also, if you present for a physical health issue do you find that people immediately concentrate on your mental health issue, because we've had some evidence from people that they go to the doctor for a physical health issue but they're classified as a mental health patient and perhaps don't get the care they should get.

MS BOYD: I've definitely witness my sister experience this on a number of occasions. She has liver issues now because she had a suicide attempt earlier this year and she took a really large amount of Panadol and it's damaged her liver and she's had huge issues in the hospital she's in getting regular medical checks because they just don't - they don't regard the mental health ward in the same way in terms of their medical needs, and so she got sepsis two weeks ago, which was really upsetting. That's been resolved now and she seems to be in a good - have good bloods now, but that concerns me. For me personally I have a really good GP I've seen for the last 20 years and I'm very cautious about health professionals I see. So I don't personally have negative experiences around that myself, but I definitely witnessed that my sister has in a big way.

MS ABRAMSON: Thank you. Just one more question. Carer support, so that (indistinct) of carer help we're very keen for them to be able if they want to to participate in more employment. So if you have any views about what would assist somebody in a care role actually participating.

MS BOYD: Giving carers opportunities to participate in the employment
in - - -

MS ABRAMSON: Yes.

MS BOYD: I personally would be really interested in helping with autism related advocacy and peer support work, and for me I guess I just don't really know how to go about it. I don't know what avenues are there. In my contractor's job two weeks ago now I ran a conference on suicide prevention and we had a lot of discussion of really brilliant peer support programs going and a lot of discussion around the skill shortages out there in terms of peer workers, and so I approached a couple of them following on from that to reach out about that, but I think there's just a bit of a lack of understanding maybe how to reach appropriate people with the lived experience or carers to bring them into that kind of work.

MS ABRAMSON: Thank you very much. Thanks a lot.

PROF KING: Thank you very much. Roger Gurr, and, Professor Gurr, if you could state your name, if you're representing an organisation the organisation and any introductory comments that you would like to make.

A/PROF GURR: So my name is Roger Gurr and I'm a psychiatrist. I am an associate professor with the University of Western Sydney and I'm representing my career long interest in funding methodology and governance with mental health. So four messages I wanted to actually get across to the Commission this afternoon. First of all I want to say I think you've written an excellent draft report, but I've got a few concerns.

So I start off with saying just a bit about my history though so you actually know where I come from. I actually started the first community-based mental health service in the city of Blacktown in the 1980s and Harvey wrote about that at one stage. I've also been an area director of mental health for six and a half years in Western Sydney covering 1.2 million population until I had to leave the job because it was diverting too much of the budget. I've been involved in the development and management of seven NGOs over the years, so I'm very aware of non-government areas. I've also done consulting and in 2008 I actually initiated the round table document on funding methodology and governance with PricewaterhouseCoopers and the AHHA, which I did send in and I think a lot of your ideas are very similar to what we actually wrote in that report.

At the moment also for 38 years I've had a foot in the private practice camps, I (indistinct) for the ground there part-time, and for the last four and a half years I've been a part-time clinical director of the headspace early psychosis program in Western Sydney. I have also as part of (indistinct) funding I've made sure I have been part of the two attempts to actually introduce activity-based funding for mental health back in 2000, 1998, 1999 and whatever it was the first one, and then also I'm an independent clinician on the mental health working group over the

current attempt, and I made sure I got onto it because I have great concerns about activity-based funding for mental health, because basically the methodology is about actually assessing, you know, trying to find factors in which you could differentiate costs, but also then it's about actually costing what's done now and then actually applying that as a way of saying, well should we actually be shrinking the funding, et cetera.

The trouble is that none of the services around Australia actually have quality models of care any sort of evidence-based, and so if you're going to apply that methodology you are going to be costing services that are totally underfunded and not actually doing the job effectively, and therefore you start (indistinct) from there and it's just a slippery slope to the bottom. So please don't support activity-based funding, there are much better ways through the contract in my view.

Also I am very much in favour of the rebuild model and certainly an advocate for commissions over the years and been involved in the establishment of the Western Australian Commission as well as worked for the New South Wales Commission. So I just wanted to tweak what you've put in there and to say I think a National Mental Health Commission not only needs to be a statutory body at arm's length from government, but much more than just a regulatory body. We really need a body like that to be the knowledge management organisation, the one that can actually consult with everybody, keep up with the evidence-base, make sure the proposals are prepared for government for which a lot of sector consensus around what should happen; it is evidence-based. (Indistinct) government's (indistinct) between what's proposed and what they actually then fund, but it does mean that there's more likely to be sensible ideas coming. So I'm very frustrated with the Public Service Westminster system in that you have public service at the (indistinct) level that are forever rotating, so they're always content free.

The state system has a few public servants but they keep cutting back on the number of people giving advice to the ministry, and really people make proposals to government from within the Public Service, but it's a real secret until the minister actually announces it. Once the minister has announced it you can't change it because the minister has announced it, and as a manager of services the number of times I then had programs presented to me to actually implement, which have no real basis with managerial process, et cetera, as six and a half years as an area director of mental health I was never once actually asked what did I think my area actually needed and what did I think the government should actually be funding. Basically it's all secrecy, and I really think that's why you need a National Mental Health Commission that can actually do things in public without the same political implications that a ministry actually has in protecting its minister.

The other thing is that also I just think the National Mental Health Commission needs to have considerable funding, because I think that the fund holder actually then has a lot of power over what actually happens, and particularly what's missing in Australia is commission research. So the current research bodies are not an easy way of getting the sort of research that I think needs to happen in terms of developing better services. We've got this thing where the universities have produced lots of papers in a short period of time and they don't tend to want to do long term perspective studies where you have to incorporate a lot of treatment activity. So a funding body won't pay for the treatment activity - sorry, the research bodies won't pay for that. So I think there are a lot of really big issues we need to be addressing and it really requires commission research.

Harvey has a role in this, but certainly the National Mental Health Service planning framework really shouldn't be transparent and available for criticism and improvement and be managed by the National Mental Health Commission, because I was working for the New South Wales Commission in 2013 when the Beta - first ever (indistinct) came out. I was allowed to read all the background papers, so I know exactly what's sort of in that initial proposal, but I was never allowed of course to actually play with the spreadsheet, and the fact that now millions of dollars have been spent on this and it's really taxpayers money, it's our money that's being spent and it should be - I tried to get it under freedom of information twice, and then finally got told it was going to be released the following year.

Well, it got released to a holding spot where you have to either be an employee I think of LHD or a PHM or a ministry and basically sign a secrecy agreement I would think to say you cannot reveal what you actually found there, and yet this again is a really key bit of information, because it was an attempt to provide a reasonably evidence-based reasonable set level of service provision across the country and the problem that happened in 2013 was once they ran the spreadsheet there was sticker shock when they discovered you'd have to spend at least two and a half billion dollars more to actually reach a reasonable level of service provision. So I know Harvey's used it in the report as well, but I just think it really - the Commission really should push that it's actually made public and not be a secret.

The other thing that I really want to talk about though, and I have a passion for this, and that is that I've come to realise that developmental trauma is arguably the greatest public health issue we face, causing most personal, family, social and economic pain and it needs to be explicitly addressed now we know how to treat it more effectively. So there's a load of evidence out there about the huge cost to society of trauma, and the trouble is we have services that say they provide trauma reform care, but that's not the same thing as actually treating the trauma.

What we know is that the trauma in childhood, adverse experiences in childhood actually change the brain. The brain is plastic and actually there are evolutionary protective mechanisms come into play which structurally change the brain to actually enable a child to survive in a toxic environment until they reach puberty. You can actually measure those changes in the brain through imaging. But once you get to puberty your evolutionary behavioural programming comes into play that says no longer are you a dependent child, now you have to be an adult, you have to compete with your peers in order to find the best mate, find the resources to raise the next generation.

A lot of those protective mechanisms then become problematic, and that's why primary care headspace sites, because I happen to sit across three of those as well, and I see from their intake meetings the young people walking through the door with obvious developmental trauma issues, and it's tragic because the headspace model does not actually have the means to look after them. They have not even got the means to fully properly diagnose what's going on because there are no psychiatrists attached; hard to get the GPs. You're relying on often very junior clinicians who on the job they get trained as their first job to do the triaging and assessment, and then you rely on some private practitioners to provide the treatment, and in areas like Mount Druitt you're lucky if you can get one or two private practitioners to be altruistic enough to actually come out there and actually see people, because there were high no show rates and cancellation rates, and it was just not economic for them.

So what we really need to do is to have an inactive program to pick it up, those people in that 12 to 25 age group and actually treat the trauma. Three-quarters of the people actually achieve suicide, people with severe and significant developmental trauma, and it's at least 17 per cent of the population that actually have significant trauma. So this is not - this is a huge number. What happens is my professions ignored it as psychiatrist, and most of the other professions have ignored it as well, and why; because they don't want to ask about trauma, because if you ask you'd have to know what you're going to do about it, and most of them have no idea what to do about it. So the client picks up the fact that their therapist is afraid and their body language shows they don't really want to hear about it, so they shut up and they don't actually tell you, and there's evidence in the literature that the people really want to tell you about their trauma right at the beginning if they can, if they feel safe and they can trust that there is actually a welcoming service which will do something about their trauma.

The thing is too that a lot of psychologists really only get trained in CBT. Now, that may work for certain sorts of trauma, but we're talking about a whole range of traumas from neglect, from emotional abuses and major trauma that's hardly researched, rather than just physical abuse and sexual assault and so on, and if you've been emotionally abused all your life exposure therapy is just not going to work. Is the therapist going to behave like an abusing parent in order to expose? No, I don't think so.

I have chaired the board of the Torture & Trauma Service in New South Wales called STARTTS for 30 years and we've been developing programs for treating every sort of trauma and we say 7,000 to 8,000 refugees a year with every type of trauma. What they have found working on a hierarchy of care model is that there's at least 15 per cent of that population who do not get better with any standard treatment, they only get better once they have neuro feedback, and now there are controlled studies for people with chronic PTSD with a whole range of other conditions, including chronic psychosis where neuro feedback is the technique that is really enabling people to become fully functional again. It's about changing the brain network activity, and the brain finds its own solutions for operant conditioning. There is 20 years of evidence. You can see it all in the American Centres for Disease Control, and also I think I put a paper into the Commission in general about trauma.

So I just think it always - it makes me emotional when I see these young people, and I think it would be very said if this important Commission and board ignores the massive development trauma issues and does not provide (indistinct) a comment and recommendations to rapidly progress our knowledge and delivery of effective treatments, and that will need Commission (indistinct). Thank you.

PROF KING: Thank you, Professor. Can I start off - and thank you also for the paper that you did provide to the Commission, because I can remember reading that on developmental trauma and I found it very useful. So I'd like to start on that, but I'd like to start recognising we're not clinicians, there's treatment there and we need to make sure that for that group, particularly in that 12 to 25 year age range that they can get access to the treatment, the appropriate treatment for their particular form of trauma.

But that still raises an issue that came up earlier this morning that I'd like to get your thoughts on. Often, the trauma is evidence in the behaviour of the child much earlier on and we heard

some lived experience examples this morning of exactly that. Where the trauma is potentially related to the family situation, how – and sorry, I'll just finish off the question by saying – and we also heard this morning from – and it was a reaction that occurred after our draft report came out is, well, you know testing children, evaluating children at that – oh, you're just going to put them on medications and that's a bad thing, and so on.

Do you have any thoughts about how we deal with that issue of even earlier intervention so that they don't actually get to the point where they need the trauma therapy?

A/PROF GURR: Exactly. Well, I mean, to me there are four phases we should be addressing. We should be addressing – and I used to do this at Blacktown Hospital - you'd see the woman in the maternity ward and you'd use the, I think it was the Edinburgh Questionnaire and you could just tell who was actually going to have difficulties in raising their children.

And the problem was, yes we have programs to send around a nice nurse, you know, a motherly figure and so on, which helped to some extent but still not actually treating the trauma. So you've got trauma passing from generation to generation. And so we really need programs that address it. I think with a 12 to 25 year old, I'm really aiming to say we want to actually address before people get pregnant.

It's really about how do we help people to actually become more settled and make better choices about their mate and actually reduce things like self-medication of drugs.

So then you've got the early childhood period, and yes, you know, a lot of the trauma happens immediately from birth or even before birth. And so that needs to be picked up when the child needs – needs need to be addressed there and then, too.

The New Zealand Dunedin study did a study following 1037 consecutive births in Dunedin Hospital. They started with a thorough assessment of children at the age of 3. They found four factors that actually explained the 80 per cent use of resources by the age of 38 by data matching in New Zealand. And the four factors were low intelligence, evidence of childhood behavioural disturbance, low socio-economic status and evidence of maltreatment. And predict 81 per cent of gaol convictions, you know. Sixty-six per cent of insurance claims because it actually affects physical health as well.

The torture and trauma, STARTTS has actually gone working into earlier and earlier and earlier into childhood because they actually find as well that some of their TPs actually work with quite young children. And so not only you have to turnaround a child soldier, you know, who's got to sit in the classroom and concentrate and learn English and whatever, they can't do it - after neuro-feedback, they can. Well, young children can actually also participate in neuro-feedback. And this is more targeted than neuro-feedbacks also used for ADHD, but it's a bit – a bit uncertain there about how good that is, because there are five different sorts of ADHD and they don't always get picked.

So I'm saying yes, we need special services for maternity and perinatal, we need special services for early childhood and we need special services for those in adolescent years because you may have missed people with our lack of attempt to, you know, screen properly our population and the various important stages.

But you also have all those legacy people then left after the age of 25, because PTSD and these trauma effects can last until death because medication does not cure it. Okay, so anyone just giving medication for it, all they're doing is tinkering with the edges and I'm saying substantive treatments like CBT often don't help.

When your brain has to react to threat and for trauma, language parts of the brain are not necessary. So the language parts of the brain don't light up and you don't lay down language memories and so you also can't talk about it in a language sense, your language therapy very well. And as soon as you're anxious and are talking in a therapy session, that also doesn't work very well. So neuroscience is really getting to the point now where we can actually see what's going on and we can actually address it.

PROF KING: Okay. Thank you.

WHITFORD AC: Roger, how are you?

PROFESSOR GURR: I'm good. Yes.

WHITFORD AC: Roger's been around a long time now, experienced a lot of assemblies. Sorry, just to come back to your question, your point about activity-based funding. So there are obviously issues that you've raised and you know well about activity-based funding and its ability to providing – as I get it, there's two issues that you raised.

One is costing classification based on existing services being forced on existing services which, you know, are often insufficient. Secondly, the ability for the characteristics of what we collect to predict the cost and that's then a challenge with DIG's for example.

A/PROF GURR: Yes.

WHITFORD AC: However, we are concerned about the need to drive efficiency in community-based services, so do you have comments you could make as to how we could deal with that in the absence of a DIG-based - - -

A/PROF GURR: Well, we've got a real conflict here because the sufficiency to get who knows where or there's efficiency around actually having something that works and you get the outcome you really want and that's what I'm concerned about is that I really passionately believe we have to be funding things for which there's a clear evidence base. And even if it requires high levels of investment up front, it is actually producing the goods down the track. That's what's important.

And the State systems are basically in New South Wales, the money just gets diverted. So when I was the area director, \$15m, I put my finger on it was actually being diverted out of community-based services. So the clinicians there cannot provide good practice. The recovery services died, et cetera.

So I think it's – with activity-based, it's a question of how do you incorporate with inter – with inter-contracted services because I think it's contracts and fidelity tools and so on that enable

you to best control what actually happens. Because then at least you may be recording and acquiring good evidence of the outcome and you're actually, you know, expecting people to actually stick to the models, stick to the evidence, because as soon as you go beyond any specialised thing and you start merging or changing things around, the focus gets lost.

I can tell you from the four and a-half years I've had with the Early Psychosis Program, it has taken us several years to really get into the groove of what it is we have to do and how we have to go about it. The big problem also with adolescent services though is the reluctance and the ambivalence about being labelled and being mentally ill and so the no-show rate is about nine – I think it's about 12 per cent and the cancellation at the last minute rate is about 27 per cent and those things don't appear in your, you know, data system. And yet, it makes it look like it's obviously not very – it's not very efficient. But in fact, the staff are very actively chasing and trying to engage work with the young people.

So I think it's – you've got to know the detail. I've been through so many accreditation processes, again in the State system to know they do nothing. I've never seen the benefit come out of a standard accreditation process. So that's why I've become reconvinced that we have to get out of the State system and we have to have commissioning and it has to be a very knowledgeable commissioning so that's the problem with PHN's. They're scrambling to try and get their knowledge base together but in fact with 31, there's just not that expertise available. And that's why I think the National Commission needs to have that role.

WHITFORD AC: So just building on that, again. One of the issues that's been put to us is that rather than trying to build the system around what is now. Build a system around what we should have so that service paying framework (indistinct) and we would agree that being made transparent to the public and being able to do advised improvement is clearly what should be happening. What's your view about trying to build a classification around, say, with something like the service paying framework would recommend for an area given it's – I guess you're going to recommend increased resources in most places.

A/PROF GURR: Yes, well, I mean, I think that's an involved – it almost has to be seen as an evolution, which is why I'm saying it should be transparent and improvable so people like me should be able to come along with an idea and say, 'Look, now I've got the evidence. I've pulled this together. Here's something that I think is worth a bet.' Because again, often with emerging things there isn't enough evidence already and so I get that criticism and I talk about neuro-feedback. There will – and they'll say well, where's the evidence, where's the evidence?

Well, there is not – there is evidence but not enough evidence, but we won't get the evidence unless we actually not only commission a search, but also create a treatment environment, and I sent along a proposal of the other I think saying it needs to be a model with a hierarchy of care model just like with psychosis, just like the (indistinct) and trauma service has where you do the simplest things with people, but then you actually have the opportunity as they need more intense or more different sorts of therapy, you can provide it because for example with trauma and with psychosis, it's not just the pills and the psychotic symptoms, it's absolutely about resocialisation. It's about recovery; it's about making sure you finish your education, get your job and actually are able to compete in the (indistinct) market place for (indistinct).

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

DR LEWIS: My name is Dr Ione Lewis and I represent Grief Journey which is a not for profit providing services for people freed by suicide. So the focus is, you know, at the stage that mental health services or health services have failed or weren't even sought by the person who has suicided and so that's a very complex field to provide services in.

So Grief Journey started out of lived experience or the people involved in Grief Journey have lived experience or suicide and, you know, are fairly critical of the services that they receive, so it's quite a different focus. But I have really appreciated all the presentations I've heard today and the care and effort that, you know, is going into services like headspace.

There's also other strengths-based, lived experience services that are springing up all over the country really and the gaps that there are in services for suicide grief people and our interest overlaps with your interest, but it isn't just mental health. It's like a vendiagram.

PROF KING: Yes.

DR LEWIS: Suicide and suicide bereavement are much larger than mental health and I actually think the focus on mental health and suicide doesn't really help prevent suicide because they're so complex and there are so many factors that lie outside of mental health.

So it's clear that during emotional distress that arises from suicide and that that probably lasts for the people closest to the person who died for the rest of their life but, you know, obviously varying intensities, and I think a recovery model is really important, that it is really possible to live a life that, you know, has quality and is satisfying. You know, from very early on, I don't think that's the message that we often receive. It's often a very hopeless message.

So the need for suicide, for people to receive effective help, support and information is not being appropriately met and in one Australia study by Wilson and Clark, they found half of the participants who identified a need for help actually received it and over half of those didn't find that satisfactory. So, you know, it's kind of an area that more needs to be done.

I guess I've got five concerns that I'd like to put to you on behalf of Grief Journey and that's, first of all, dedicated suicide bereavement services often exclude people who are newly bereaved by suicide from accessing ongoing support groups because they're too distressed without offering services.

But if you look at services for victims of violent crime, that is not at all the case. There is, you know, great care taken to offer support to people, you know, in their early crisis stage. So two very similar experiences, homicide bereavement, suicide bereavement, very different response and we can't help feeling that stigma and discrimination have a lot to do with that; those stigmas around suicide.

And professional practices in suicide bereavement are exclusionary and unwelcoming. For example being required to attend face to face screening interviews prior to being admitted to a

support group, even when that involves travel, and also delivery of support groups inside business hours and this dominant model of groups is also discriminatory and unhelpful because people naturally need individual support.

Indeed, if somebody is very distressed, it's a very good idea to offer them individual grief therapy and I think there's quite a, you know, lack of tolerance for intense grief in, you know, our cultures as well. In Australia where it's not really acceptable to be expressing grief, so even at funerals people can told they've been very dignified; that means they didn't cry. You know, they've definitely got that focus about grief.

And I think it's really important that people with just as mental health consumer movement which is so inspiring that people with lived experience of suicide and experience in supporting people bereaved on a suicide should be consulted and there really is that need for very early support by people who are further along in their grieving than the acutely bereaved person. I think that's very useful and just in my community I've done things like had walks with people.

I'm a very experienced therapist, 35 years of experience, and I'm an experienced academic, 25 years of experience, but I simply can't go past a walk saying, 'You've already lived through your worst day. You can survive this and life can be good again, but it will be different; a different life,' and I think that's very helpful.

I think also we shouldn't just think about therapy services. I think you need to think about - you often need mediation services. There's a lot of conflict about funerals; access to ashes, wills, a lack of wills, so we need things like mediation services. People are packing up houses, they need support with that. They might not be able to live in the house and they might need support to live elsewhere because the suicide happened in the home. People need assistance to visit the place. There's a lot of sacred places for people around the country when you look at the number of suicides each year. Now, there needs to be visits to those places and (indistinct) realising and that is very helpful for people's recovery process.

There's a need for advocacy, financial support. If you think of somebody newly bereaved on Newstart, they're just going to get breached. You know, they're not going to be able to make those responsibilities and actually a grief benefit was removed from Centrelink. So, you know, we have this huge area of unmet need. There'd be impact on people's work lives, inquest years later where people need leave and support. So there's this ongoing process that is inadequately resourced, except by people bereaved by suicide doing it for each other.

And also, obviously services need to be tailored to the cultural needs of local communities. So if you look at what's happening in the Kimberleys, you know, obviously the way that is responded to is very different and I have done training in working with suicide bereavement in WA at his year in four communities, but we're very concerned about, you know, rolling kind of deaths where one triggers another.

And I also would like to comment that we've got a popular model of combining suicide prevention and suicide bereavement services in one service. For example suicide call back service, and they say that they provide services to suicide effected people. But really, there's quite a paradigm clash there between what you need for somebody who is suicidal, as you would all know, and what you need for somebody like me on the other side. It's not the same

skillset, it's not the same philosophy. But you know, somebody suicide bereaved, needs to accept that the suicide happened, but with someone suicidal – somebody who is suicidal, we don't want to accept that they're going to suicide, we want to actually give them the message their life is precious, and we want to prevent that death.

So, there's very different models, there's very different philosophies, very different professional skills needed to work with suicidal people and suicide bereaved people. And also people bereaved by suicide are often very aware of the lack of services for the person who died, and they frankly don't want to take up the time in a crisis service. Why would we want to do that? The suicide rate is not going down, you know? It's a continuing crisis, especially for 15- to 24-year-olds.

Health professionals are not adequately trained in grief. I speak as a social worker and a psychotherapist who did the training that Scarlett referred to this morning, the west – out of the Westmead program. Trauma was a big part of that, but grief was not, and if you look at the accreditation standards for the different professions, grief, you know, doesn't play a big part in those accreditation standards a lot of the time. And this, you know, this certainly is interested in training. I think people – there was really a huge attendance, recently, at the mental health professional online training. I think there was 1,600 people attending that, so there is a lot of interest, but you know, that also isn't very in depth, it didn't give you skills for how you would actually work with somebody who's suicidal, let alone the post-(indistinct) part of the presentation.

Also, I think it's really important that service models are not the dominant model in mental health delivery, which is cognitive-behavioural therapy. It should be based on attachment theory. That could be any model, narrative therapy, Michael White wrote a beautiful article about saying hello to grief. You know, lots of counselling and psychotherapy models have the understanding of normal grief. Newly bereaved people have received very inappropriate psychological treatment, that conflates normal grieving with negative cognitions, which is not a negative cognitions.

And so it made a number of recommendations for what could happen short term and medium term and long term in my submission, and just a chance for any questions that you have. Obviously, I'm very passionate about - - -

PROF KING: Thank you. So I guess, where do you see the funding for suicide bereavement services fitting, I guess, within the model? Because whilst, as you say, not everyone who suicides is mentally – has mental illness, not everyone with mental illness has suicidal ideation, and so – and now we're moving a step further. We're saying, well, people who are grieving a loss, due to suicide. So I'm sort of thinking, well, where does that fit? Does that come under, in a sense, our enquiry? Is it a mental health service, or is it - - -

DR LEWIS: Yes, I think that's a good question. Or, you mentioned suicide quite a few times in your report, so the outcome of suicide should be considered, I think, by your enquiry, by the recommendations shouldn't fit within mental health services, and I think the senate enquiry into suicide, in 2010, I was an expert witness for the senate enquiry, on behalf of my peak body, and you know, that said there should be a national strategy for people who are suicide bereaved, and that still hasn't happened. You've got this ad hoc funding, or I've got this little service here

in Victoria, so let's fund that. And you end up with someone based in Wagna, who I met recently, providing crisis support to suicidal people, NDIS, advocacy and suicide bereavement for nearly the whole of New South Wales rural areas.

So, you know, we need to think about where this funding should sit; Department of Health, or, you know? We need to think about that, but there hasn't really been any discussion since the senate enquiry on a national level about suicide bereavement.

PROF KING: Okay. Perhaps, follow that up, and apologies if this comes across as slightly ignorant, because suicide bereavement is not something that I've looked at or thought, really, of strongly, before, but of course bereavement, more generally, particular – you know, so, for example, you know what people who have been in long term relationships, and one partner dies, that that quite often leads to mental ill health. Is suicide bereavement significantly different from more general mental ill health, or issues that are raised from bereavement? So, is it – I understand the different – yes?

DR LEWIS: I think the issues that are raised are different, because there are police involved. They seize things, that's the language, they've seized things in the home. There could be a coronial inquiry, there could be an inquest, there could be issues about insurance, because the person died by suicide. So I think the – the experiences that come after a suicide death are very different, but grief – there's very similar grief experiences, however the person died. Of course, there's thing in common, but you're dealing with really unique challenged, just like telling, breaking the news to people. It's actually the suicide bereaved person breaking the news to people, actually holding a committee of people, sometimes young people, going through their first loss.

So, you know, there's one of heroes, really, doing that. They do a lot of caring and holding, you know, while they're acutely bereaved. People cry, when they talk to them. They often end up just like homicide bereavement, looking after the person that they've told. Yeah, I think it – I think there's different legal implications, but, you know, there's things that are in common as well.

PROF KING: Thank you.

MS ABRAMSON: Could I just ask, and thank you for coming today, what the best gateways into such services? Because family would know immediately, be connected with mental health issues, because you might be the first time that they knew that there was a problem.

DR LEWIS: That's true, yeah. Well, GPs would be, but I think people go online. So, there's a little group in Bunbury, WA, that has an online group on Facebook that's a closed group, and they also meet, and they provide things like childcare, which often don't think about in planning a service. And there's very complex, you know, supports that they're providing. There's an online group that has over 60 members now on Facebook, a closed group called Australian Suicide Loss Supporting Each Other, so people go on Facebook or Google and find the services that are out there. I think they're very comfortable with a peer model, because it's not judgmental, it's not been provided by a health service that perhaps let them down.

MS ABRAMSON: Also, wouldn't there be – I mean, we've had this in other areas, a danger with people accessing services on the internet without (indistinct), because I'd imagine that there will be some things that people see that will not be helpful. So is it something that you see as a kind of process?

DR LEWIS: Well, no, because I'll tell you why I think that. I think people are acutely disempowered by suicide; they've lost control over their life, and I think that they need to find the service that's best for them, and I also think, like a lot of the health service pamphlets, are quite hopeless, and they, you know, talk about outdated theories like stage theories of grief. You know, there's some very poor quality to the services, and the people will be having contact with the coroner's office, but they might find that a very difficult experience and need support with that as well. So yes, the coroner's office would be a central place that everybody is having contact with, all around the country, but not necessarily a therapeutic experience.

MS ABRAMSON: I had understood, and I might have this wrong, but a number of the coroner's reports have put a lot of effort into the support that they will provide to families, but of course not every suicide is going to result in an open coroner's inquest.

DR LEWIS: That's right, yes. Well have you ever seen a valuation of a coroner service?

MS ABRAMSON: I haven't, but I have been involved with the coronial service in unfortunate circumstances.

DR LEWIS: Yes. So I think there isn't a lot of research on how families experience coroners courts and social workers in coroners courts, and I think they vary vastly across state and territory lines in what they – even what they see as their role, actually.

MS ABRAMSON: No, I've certainly seen that as a practicing lawyer, which has been my experience (indistinct).

DR LEWIS: Yes, yes, yes.

MS ABRAMSON: (Indistinct.)

PROF KING: Thank you very much. Let's break now for afternoon tea, and resume at 3.40.

SHORT ADJOURNMENT

RESUMED

PROF KING: So excuse me. Let me restart after afternoon tea, and apologies for getting called out just then. Gita, if you would be happy to say your name for the transcript, any organisation you're representing, if you're representing an organisation, and any opening comments that you'd like to make.

MS IRWIN: My name is Gita Irwin. I have been a carer for my mother, who suffers chronic depression and low functioning bipolar disorder for over two decades. I don't have an affiliation with any particular organisation, but I have done stuff with Carers NSW, et cetera.

PROF KING: Yes, and if there are any opening comments you'd like to make.

MS IRWIN: I've been looking after my mum for two decades, and over that time, I've had dealings with public hospitals, pretty much all of them in this district: eastern suburbs, inner west, hell, even Sutherland. I've had dealings with private hospitals, and I've had dealings with alternate therapies and all kinds of things. We've tried everything to conquer this. And during that time, I've noticed certain things that worked and certain things that didn't, and I had a look at your - the report, (indistinct) to be honest I had a look at the overview. The report is massively long.

PROF KING: Very long, yes, apologies.

MS IRWIN: And so I came here today to address a few things that I feel needed clarification, others I felt were missing. I wanted to have a talk about inpatient environment for those who do manage to get inside hospital beds. I wanted to talk about lack of social interaction. I wanted to talk about simplicity of access to care and affordability of access, which is a big issue for a lot of people suffering mental health.

Recently I had an experience – my mum's condition is such that there's peaks and troughs, so you'll have times where she's functional and it's all great, and other times where she just crashes. And I recently had an experience where she crashed and it was crisis time, and I couldn't get a hold of any mental health assistance. I called the acute care team, because that's what I've always been trained to do, is to go to them first. Couldn't get them on the phone, got an answering machine, and then the first appointment we could get with the psychiatrist was in three months' time, which leaves my hands kind of tied for three months.

PROF KING: Yes.

MS IRWIN: So why didn't I look around for other psychiatrists? I did, but my mum's an aged care pensioner, and all those other psychiatrists wanted to charge 400 to \$500 an hour. And it's not that she's not worth that, it's just literally, we don't have the money to pay it, and even if you get your Medicare rebate, whatever it is, you're hundreds of dollars out of pocket. And it makes me wonder how it is that people get mental healthcare if they can't afford it. And also, there's the other thing of access. A lot of psychiatrists we called, they said their books were full. Like it seemed to be they have a set quota of patients and they were full, like, "We don't have any space, his books are full, her books are full." I can list a bunch of names that this happened to me recently, it's a new clinic. I don't think that's necessary though, you get the point.

PROF KING: No. I understand, yes.

MS IRWIN: But this is a nation wide problem, from what I hear, so I know my experience can't be unique.

PROF KING: So when - - -

MS IRWIN: What happens is it leaves people like us who are carers or family members – I mean one of the great crises of mental health is it doesn't just affect the mental health person, it affects their environment and the people around them, especially the people who are trying their best to look after them.

PROF KING: Yes.

MS IRWIN: So you're forced to make sacrifices of your time, money, energy, whatever because that access is not available and it's not affordable. So there's point one.

The point two, the inpatient environment care. I've had several occasions where my mum has been admitted into inpatient facilities in Prince of Wales and St Vincent's Caritas and then Sutherland and I've had some really traumatic experiences in that time. I mean, the few times that she ended up in the Kiloh Centre, sometimes it was without even my permit or approval because I would put her into private hospitals, thinking, oh, we've got private healthcare cover.

MS ABRAMSON: I'm sorry to interrupt you but because it's a public transcript, could I get you to talk in general terms about the places that and the experiences that you've had?

MS IRWIN: Well, in the private hospitals, in the public hospitals that we've had, the way the system works is for those who are fortunate enough to have health insurance, which my mum does.

MS ABRAMSON: I'm sorry, it was more about naming institutions.

MS IRWIN: Yes, not name. I will try not to name them. But the way it works is you go into a private hospital but if they think your case is too acute, they will transfer you into a public acute facility and unfortunately they do not always notify the carers or relatives when they do that. So you get a nasty shock when you turn up to visit and, oh, she's been moved to whichever institution. And then when they get inside those places, they're put with a whole assortment of people and there's no consideration to their individual state and the suitability of the environment that they're put into.

In my submission, I likened it to a gaol in that with gaols minor crooks are put with major crooks and there's been lots of studies on what a disaster it is because it gets people exposed to all kinds of undesirable elements and I'm not saying that different people shouldn't be put together but I do feel that there are different stages and levels of mental health and that should also be assessed when they're putting people into an inpatient environment, because it doesn't do either party any good to do that. So my mum came out of those episodes deeply traumatised and really upset.

PROF KING: So from the clinical environment she'd been put in it actually added to - or created trauma.

MS IRWIN: Yes, I went to a mental tribunal to get her moved, okay, and luckily I got that one that happened and she went to another facility because they're not all bad.

PROF KING: Yes.

MS IRWIN: But unfortunately a lot of them are.

PROF KING: Some of them are.

MS IRWIN: Okay. And sadly in the mental health system it is very much - it's an individual basis thing on who you get. I'm not going to name names but some people are a lot more compassionate and sensitive to than others are, and so it is luck of the draw.

PROF KING: Yes.

MS IRWIN: There's no unified system in place for dealing with people, you know, and on that occasion I got lucky and we got her into a place where it was a quieter environment, less people screaming at her, abusing her, you know, she had one case where she'd been urinated on. It was so awful. And when I got her moved, all of that disappeared and so her trauma gradually lessened after a few weeks and the place that I got her to move to had a - I don't know if I'd call it a holistic program but an integrated program where they (indistinct) physical therapy, they looked at her diet and her medication. But anyway, they looked at several elements and they also did things that promoted social interaction, they have activities with people and they took them out for walks and outings and stuff, which is fantastic.

PROF KING: Was that still a public facility?

MS IRWIN: Yes, this was a public facility. It was a rare program and as far as I know, they don't offer the same thing now.

PROF KING: All right. So they may have been trialling it, for example, and - - -

MS IRWIN: Yes, I don't know what the situation is, I just know we were very fortunate and which brings me to my fourth point which is I do feel that the programs that are given to people in mental health are not looking at their entire circumstances. A lot of these people are very lonely and there is a lack of social interaction and there are programs out there that help you with that but they are short term programs. The ones that we were accessing through public health, community healthcare facilities usually lasted for about three months to one year and they were great while they were on but then after that she crashed back down again. And I can't expect them to last forever but some sort of facility or organisation which enables and encourages people to socially interact because you're talking about people who struggle to get out of bed in the morning. To tell them, oh, you can go online and find this is not going to help anyone. The people who come to your house and take you out and take you to places and get you involved in activities and once you start lifting, that encourages it.

PROF KING: Can I just - on that, if those services were there, so as you've said, your mother has cyclical episodes, as you put it, she crashes, ends up in hospital, if the in community supports were there, if there were the services where someone came around and took her out, helped her engage, mix with other people, there might be other peer support might be provided, do you think - I don't want to ask this as a clinical question but do you think that would be

effective in helping her not crash out? I mean, have you noticed anything where when her condition deteriorates it's because she's not getting that sort of interaction or - - -

MS IRWIN: Look, I would love to give you an easy answer and say that's a one all fix but in my experience, like I said, I can't speak for other mental health disorders, I can only speak for what acute depression's been like and living with it. Yes, it's a mixture of getting the medication right, the social interaction right, possible alternate therapies, diet, exercise, it's a multi-pronged program and that's what I want to see, somewhere there's a multi-pronged program. And what I would like to see is a case manager. I shouldn't have to chase five different organisations to get one whole integrated service. Because I'm having to call this, call that person, call that person, I'm playing snakes and ladders on the phone every week and I am bloody sick of it.

PROF KING: Yes. So and you may not have - I'm not sure if you noticed, but yes, we actually recommend, for example, for acute depression, severe depression, we actually recommend that there should be case managers to make sure that people can access the services, they know about the services, that they're linked in to a complete team of care, I think we call it in our - - -

MS IRWIN: There's supposed to already be that system in place but you seem to get one and then they seem to fade off and you lose them. Like the psychiatrist, I had no idea that mum had not seen the psychiatrist for a year. I was like, how did the year pass and we didn't see a psychiatrist. You know, we had one. Don't know where he went but he went. You know, now I'm having to get her on to another program and hopefully that person will help me get a case manager and I've got to jump through these hoops again.

PROF KING: Yes. Just on - sorry, I've got two thoughts that are going in the same time. Just on your role as a carer, so you said that your mum, for example, gets moved from private facility to a public one and you're not even notified. One of the things that we've been tossing around is an idea of we'll call it an advanced care directive where when an individual, when a consumer is stable, when they're having a good patch, when they're in recovery, they can then nominate, well, these are the people that I want involved in my care and when I get to a point where I've deteriorated and I really need others to make the clinical decisions or the relevant service decisions for me, these are the people I want to make them. Do you think that would help? Would that be something that your mother would be interested in being part of?

MS IRWIN: Well, see, I thought about this and I got what was called a general power of attorney, thinking this was going to fix this problem. I would leave the paperwork with people and clearly they did not look at it or consult it because decisions were made without my authorisation or at least my acknowledgment of involvement.

I mean, the other thing is that the challenge is getting into a private hospital in the first place. Beds are rare and highly in demand and you can be on a waiting list for that as well. So and they're not the be all answer. Sometimes I've had better service in the public health system. Like I said, it's very much who you're dealing with at the time.

PROF KING: Yes, but you're exactly right though. I mean, we've seen in other areas where advanced care plans, the clinicians tend to have a habit of ignoring them.

MS IRWIN: It's extremely frustrating. Also, it doesn't seem to be a system where everyone can look at the history. I would've thought there was an online system by now, maybe there is.

PROF KING: No.

MS IRWIN: There isn't?

PROF KING: No.

MS IRWIN: And you're always having to reexplain the same thing to every single doctor and I'm like, we have an online database now for everything else, why can't we just have one where all the symptoms, all the history, everything's there, they could look it up, they could be informed and not waste my time with questions they should already know.

PROF KING: Yes. No, we agree completely with that (indistinct). I've said in another forum, but I think it's amazing that we're in the 21st century and we sort of seem to be, well, maybe at the beginnings of the 20th century in terms of our getting data together and having an integrated consumer controlled data that's built around health but - - -

MS ABRAMSON: Can I ask a couple of questions, first of all, thanks very much for coming to talk to us today and I can hear how frustrating this experience has been. I want to ask two questions, the first one was you mentioned the mental health tribunal. So I'm interested what your interaction was with them and why you needed to go there?

MS IRWIN: Well, I've had two engagements with mental health tribunals. One felt terrible at the time but it ended up doing good, which is one where they demanded to keep her in there longer when I wanted to take her out there earlier. In the long term, they were right, because they were trialling a new med and actually needed to be there longer.

You know, so but the other one where I had to get her moved, I had to apply, I had to put in a submission, then they had the tribunal and I was allowed to speak and say my piece and go, look, this is not working, she's in this acute ward, this has happened, this has happened, you know, is there a better place for her? And then they gave me that other mental health team in the same hospital, they had another unit, and said, well, we can try and put her here and see how this works.

My only complaint about the whole situation was I wasn't told how long the duration would be and so just when she was improving they discharged her and I was like, oh, keep her for a bit longer and just let her get to that one step, you know.

MS ABRAMSON: So it was because she was an involuntary patient that the jurisdiction of the mental health tribunal - - -

MS IRWIN: Yes, yes, as far as I understand it, yes.

MS ABRAMSON: Yes. No, I understand. The second thing was you managed to get your mum into a good program, I'm just wondering how you found that program?

MS IRWIN: I'm looking online for stuff all the time and asking. I mean, so one of the programs was referred to me through Carers New South Wales, which is an organisation I got in touch with. They were much better a few years ago before they underwent a whole bunch of budget cuts, but I'm told there's supposed to be a new program coming in called Gateway or something and that will be wonderful. But they referred to a carer respite program that had a whole bunch of activities for my mum and was run through this hospital facility in the - can I say the name of the hospital? No. Okay, but eastern suburbs hospital that everyone knows about. It was run through them and they did this program.

MS ABRAMSON: We're not so fussed about the name of the institutions but we're just fussed about naming individuals part of them.

PROF KING: Yes.

MS IRWIN: Anyway, Prince of Wales had a Euroa unit and the Euroa I think is still there. What programs it runs, I don't know. But at the time it was run by a professor who was trialling, he was very determined to try and fix my mum and so he was trying everything, you know, he had her attached to the Black Dog Institute and trialling magnetic therapy and trialling basal nerve therapy, they - anyway, DVT or whatever it is, but he had her trialling a whole bunch of stuff. Some worked, some didn't but I appreciated his effort and the fact that he also got in a program where you got an occupational therapist and we got a physiotherapist out of that. Didn't last forever but hey, for the six months it did, it was great. She got out of the house and got her out of the bed and got her out of her evil smooPROF KINGorner and got her doing some physical exercise, which is - - -

PROF KING: Important, yes.

MS IRWIN: - - - a real achievement when it happens, you know.

MS ABRAMSON: When you looked at the online services, were there any that had consumer reviews or consumer reviews as the main (indistinct)?

MS IRWIN: Not at the time, like I said, this particular episode is going back a decade ago. I've in the interim had different experiences and taken mum overseas and trialled alternative therapies and stuff, that's also a mixed bag but this commission's not about that. But at that time, no, there was no online reviews or anything like that.

PROF KING: Thank you very much.

MS IRWIN: You're welcome.

PROF KING: Next, Arsho. And if you could state your name, if you're representing an organisation, your organisation, and any opening comments that you'd like to make.

MS KALLOGLHIAN: My name is Arsho Kalloghlian. I represent The Grassroots Approach Programs organisation. It's an organisation that creates programs for mainly about relationships and I also read the draft report and I agree that there needs to be preventative measures put in place for mental health and addressing parents and addressing it at preschool

level and school level, I absolutely agree but the way I would like to approach it actually even further back than that.

The grassroots of - I believe in society are the senior high school students and by addressing it at that level before they leave school, I believe you get a lot more people empowered and knowledgeable about how to do relationships well. So with the current divorce rate being almost 50 per cent and half of those involving children, it is dysfunctional and highly conflicting family situations that have a huge impact on children and it affects their schooling, it affects their anxiety, their ability to learn. It affects at many levels.

There's quite a few research that shows the impact of conflict family situations or divorce of parents that it has on children and through teaching the senior high school students relational skills that will help them develop healthy environment, healthy marriages, healthy couple relationships, it actually does help bring up the next generation to be a lot more secure and trusting and mentally, physically, emotionally healthy.

So The Grassroots Approach Programs has two programs, one is for teachers, which has currently approved by NSWESA, the New South Wales Education Standards Authority, and that is about teaching teachers awareness as to why some students may be struggling, why they don't have the capacity to learn like the other students do and how to help those situations. And it all comes down to relationship that the teacher has with the students that promotes the students' capacity to be able to learn and retain knowledge, not just learn but actually retain knowledge and then be able to express that knowledge.

So that is the crux of what I do and I believe I'm really disappointed that along with STEM subjects, the PDHP subject that does - - -

MS ABRAMSON: Would you be kind enough to spell out for the transcript what the acronym stands for?

PROF KING: PDHP.

MS KALLOGLHIAN: PDHP, personal and physical development, education development. So it teaches very basically wellbeing skills, tolerance, respect and all those sort of things but as anyone who's been married knows, that once you're in a relationship, respect isn't enough, you really do need relational skills that are going to stop your relationship from downward spiralling.

There was a research in the US that was carried out on 509 couples who are divorcing to find out what was the most common reason that couples divorce and it was found that majority of them were due to unrealistic expectations of what marriage should look like and lack of commitment. So based on that, I think it is important to talk about and normalise what relationships look like, the difficulties that are not (indistinct) but most certainly will arise and talk about the different phases that every relationship goes through and how to navigate through the second most difficult phase which is the conflicting phase, the phase two which all conflict comes out, differences come out and it's quite often the couple don't have the skills to navigate through those conflict stage and it leads to separation and divorce or just getting stuck in that dysfunctional relationship.

So the 50 per cent that do remain married are not necessarily all happy marriages, functioning marriages where children are being brought up in a healthy environment.

So what I would like the productivity commission to do is actually address this with the educational minister about introducing a relationship model that every single high school student has to know before they leave school and has to be able to - it's not just for marriage, those relational skills can actually be applied at work. A lot of people constantly are changing work because they don't get along with the people that they work with. As soon as conflicts arise, it's no longer a pleasure to be working in the company, doing the job that they love doing. So these relational skills will actually help in the work place as well as in friendships, in family, but most importantly within marriage.

PROF KING: Thank you. Just a question on that: so you're focused on seeing your high school, and I can see why from the point of view, particularly with the perspective of marriage and relationships in adult life. I wonder though, have you thought about whether it really needs as program throughout schools? So one of the things that it meant to exist at the moment, is social and emotional wellbeing programs, right throughout the school curriculum.

MS KALLOGHLIAN: Yes.

PROF KING: And we've seen a mixed bag, and it differs between Australian states. But I was wondering if you've thought about whether the sort of program you're talking about is really – rather than being a separate, standalone program for senior high-school students - - -

MS KALLOGHLIAN: (Indistinct).

PROF KING: - - - whether it actually fit into a more integrated program.

MS KALLOGHLIAN: Absolutely. Absolutely. And that was my purpose for also doing a professional development program, because it actually – the teachers become the role model for the students of what a good behaviour is, what caring attitude is, and all those kind of behaviours. Whereas, I think, when children experience compassion and caring attitude, they know that that is the right way to behave, that that is a desirable way to behave. So it can be integrated at every level of the schooling times. And it is derived from psychological perspective, so we do talk about emotional intelligence.

We talk about what does love and happiness actually mean, we unpack it, because everybody wants to be happy, everybody wants to – they think, you know, falling in love is – that's all you need in order to have a happy marriage. So, there's – nothing could be further than the truth. So, just to expose that, those realities, before they leave school, so that when they then – we also teach about thinking about the end from the beginning, when you are getting into a relationship. If you are getting into a casual relationship, what is it going to look like if either one decides that they're not – they don't want to say, even if you never intended – so we do prepare them in so many different aspects, and get them thinking about making healthy decisions and choices, and not to be getting into it without knowing the skills. And we also integrate how to raise healthy children. The fundamental things that every parent should know in raising children, and yep.

PROF KING: So has there been any, I guess, longitudinal study, so looking at the program, seeing how that's effected the relevant students, as they've gone forward, over the next 10, 15, 20 years, to see, you know, does it – the gold standard would be, does it have an effect on divorce rates? Are the children, or the students, 15 years later, in better relationships than cohorts who haven't done that yet. Has there been any formal studies on that, so that the evidence - - -

MS KALLOGHLIAN: It hasn't been around that long, for them to study. But the first group of students that did sit through the program are now third year into their adult life, and I have actually had emails saying that it has helped them in their work situation, just knowing how to help someone who does have dysfunctional behaviour, and they have been traumatised, they haven't come from a good place; how to actually promote healing in that person, just by role modelling, caring attitude towards them. So, instead of reacting, actually being proactive, and setting the culture instead of reacting from the culture that's already there.

So I have had a letter from my first students, but the greatest impact has been from the teachers who have sat as supervisors, during those classes, who have said it has actually transformer their relationship. Just by knowing that, you know, forgiveness is not something that needs to be earned, that it's something that you do because you're a forgiving person, you respect because you're a respectful person, not because the other person deserves it or earns it.

PROF KING: Okay. Julie?

MS ABRAMSON: Just one thing I wanted to ask, we have a very crowded curriculum, and the pressure on teachers is enormous. And it was my understanding, and I may have got this wrong, that social and relationship skills are built into the way that teachers teach these days?

MS KALLOGHLIAN: It's very platonic. It's very platonic, and the students themselves - - -

MS ABRAMSON: Could you explain what you mean by that?

MS KALLOGHLIAN: Sure. I've had students say that nothing that they learn at school – this is a year 12 student who said this. Nothing that they learn at school comes anywhere close to the reality of what relationships – yes, they learn respect, and tolerance, and, you know acceptance and all those sorts of things, but none of those things actually prepare a person for real life, and the conflict – you learn conflict resolution skills, but it's like, it's actually adopting a particular attitude in order to resolve that conflict. It's not just about clear communication. There is so much emphasis on communicating. Two people can communicate very clearly how annoyed they are, or how disappointed they are, or how, you know, what the other person is saying is not acceptable, so unless the attitude is changed, clear communication alone doesn't resolve conflict.

MS ABRAMSON: You see, our opinion one way or the other is just for the purposes of what we're talking about; do you see the school, why do you see the school as the place to deliver relationship, what's the word, it's not advice?

MS KALLOGHLIAN: Skill building program. Yep.

MS ABRAMSON: Skill building, capacity building.

MS KALLOGHLIAN: Yep. Because once they leave school, it is very unlikely that they will seek to learn about relationships. There seems to be a common belief that everybody knows how to do relationships. If things go wrong, it's the other person's fault. It's not something that people look for. So I believe the best place is the senior high school, because, they are old enough – and sometimes they have even experienced being in relationships, so they can relate to it. And they're old enough to understand it, and then hopefully the – what they learn in here will stay with them through their life.

MS ABRAMSON: Thank you.

MS KALLOGHLIAN: As a preventative measure, rather than – I'm a psychotherapist, and I have my own private practise, and I do look after marriage – marital conflict, quite often, and I believe prevention is better than cure. Because once the marriage does get to that dysfunctional level, it becomes very, very difficult to change habits, to change behaviour at that stage. So for me, it's prevention is better than trying to heal it at the other end. And about the crowded curriculum, I also do EAP in schools, so I did before, and quite often on another note, teachers are overworked. They are overloaded, and a lot of them say their work doesn't finish until 7 pm on that day. They have a lot of reporting to do, preparation to do, and it is affecting their own family relationships, their own mental and health wellbeing.

So I think that's another thing that needs to be looked at, is to actually lighten the load on the teachers, because a lot of them are leaving the work that they love doing the most, because of the amount of work that they have to do, and it's affecting their health and their family relationships.

MS ABRAMSON: Thank you.

PROF KING: Thank you very much. Next, Shelly Wilkins. And again, if you can state your name and your organisation which you're representing, and any opening comments that you have.

MS WILKINS: Thank you. Good afternoon. My name is Shelly Wilkins. I'm the Executive Director of the National Office of the Citizens Commission on Human Rights. We're an international organisation, and we were co-founded in 1969 by the Church of Scientology, and Professor of Psychiatry, the late Dr Thomas Szasz. And we were established to investigate and expose psychiatric violations of human rights. That's the only area that we work in, and we assist people that have been harmed within the system to lodge complaints, work with their lawyers, and do what, you know, various types of action to assist them. We conduct education campaigns, we have an exhibition. We fill the gap of providing the knowledge about psychiatric drug warnings, and you would have heard the – you know, the consumer information is not in the packets, this morning in various types of things. So that's, in a nutshell, our organisation.

Okay. So, mental health in Australia has received record funding of \$9.1 billion in 2016-17, which is an increase of 31 per cent on the previous six years. The contrary fact is that despite

this, we are told we are sicker than ever, and not getting better. We can only ask ourselves, 'What is being done with these billions, and why aren't there clear, reliable outcomes?' It is time for a cold, hard look without fear or favour to dig into this, and this is what we ask of the Productivity Commission.

I want to say clearly at the outset that this is not a problem of more funding.

Having worked in this area now for more than 20 years, I know that it one of accountability and results for dollars spent, and continuing to fund - and of continuing to fund treatment with measurable harm. Where are the results for the financial investment already made into a system where patients are not truly helped?

Why isn't the government demanding results such as decreased numbers of people and children being labelled with a mental disorder and decreased psychotropic drug reliance? The use of psychiatric drugs has reached an all time high. In 2017/18, there were 4.2 million Australians taking psychiatric drugs. This is actually the equivalent of the population of Western Australia and South Australia combined.

Accompanying this rise are the 47,000 adverse drug reaction reports made to the Therapeutic Goods Administration for antidepressants, antipsychotics, and ADHD drugs, and this includes over 1,700 deaths. Of these deaths, over 700 were linked to the antipsychotic Clozapine, and each death represents the loss of an individual person with family and friends. Imagine 700 people dying after eating foods with harmful chemical additives. There would be a national outcry, and the additive would be pulled from the market and banned.

Appallingly, Australia is among the top five countries in the world taking antidepressants, and suicides are increasing as you've heard, and as your report also covers. There are now 67 Therapeutic Goods Administration warnings on psychiatric drugs, including seven that warn of the risk of suicide with antidepressants. The Australian government has not approved the use of antidepressants for children under 18 for depression. Despite this, in 2017/18, there were over 100,000 children under the age of 17 on antidepressants.

It's no wonder that since 2008/09, suicides in young people have increased 40 per cent, while at the same time antidepressant use has increased approximately 60 per cent. So this link between psychiatric and drugs really needs vital investigation, and obviously, clearly not everybody who takes an antidepressant will commit suicide. But the Australian government - and the results are out that clearly there is a link there, and it does need to be looked at.

And then when it comes to, within the draft report, the screening of zero to three-year-olds. We're quite concerned about that, and it's a shame Professor Whiteford is not here, because would have, you know, appreciated hearing his questions, you know, to me about this area. The screening of zero to three-year-olds will be based on a checklist, on a subjective checklist, and if you look into the area, you can see that it will be based on, is the infant or the toddler, are they whining, are they crying, are they missing their parents when they leave, are they not sleeping, are they eating irregularly, and then, you know, are they hyperactive, and these types of things.

And it's based on a checklist. There are no scientific tests to prove that any child or any adult actually has a psychiatric disorder; not something that I'm saying, the main psychiatric manual

used in Australia actually states that. The Diagnostic and Statistical Manual of Mental Disorders, that is, and the Pharmaceutical Benefits Scheme use DSM-5 and Medicare are using DSM-4. So we're quite concerned about the increasing number of infants and toddlers that could potentially be put on psychiatric drugs, and at risk.

In 2008/09, we already had children under the age of one on psychiatric drugs, and we, as an organisation, we have to pay to obtain the statistics for by age of the numbers of children on drugs. Last time I did this, it cost of \$5,000, and the public have a right to know, because this is part of accountability and part of monitoring. So now we cannot get the age breakup for under six, so I cannot tell you how many children under one are currently on a psychiatric drug because it will not - they won't - will not provide it.

So what is really long overdue for is an impartial look at what is really occurring. An honest review of the drug and brain interventions, and failing programs like headspace, where we say enough is enough. Fund and implement programs and mental health care that doesn't harm, leaving in its wake so many children put on mind-altering drugs.

I would like to draw your attention also to some other key problems. Why is it that only in the Western Australian Mental Health Act is there a criminal fine levied for failing to report sexual abuse of a patient by a staff member? Why is it that in Victoria there are no criminal fines or prison terms for ill-treatment or wilful neglect of a patient in the Victorian Mental Health Act? Yet if a person wounds, mutilates, abuses, worries, torments or terrifies an animal, they can be fined up to 40,000 or imprisoned for up to 12 months under the Prevention of Cruelty to Animals Act in Victoria? I'm sure you agree there's something very wrong with this.

And speaking further about abusive treatments. Why should a vulnerable person in desperate need of compassionate help be forcibly restrained and dragged down the corridor to the given more electroshock after they've already had so many of them? And why should their parent have to go to court to stop the electroshock? Because electroshock can cause brain damage, memory loss, cardiovascular complications, and it can cause death, and the father obviously could see in his son what had actually happened to his son. And this is not just a one instant. We take the calls at CCHR every single day.

Medicare actually funded over 36,000 electroshocks last year. Western Australia bans the use of electroshock on children under 14 years old. Why hasn't every state and territory afforded children this protection? Why is electroshock even on the market? Because there's the invented term, 'treatment resistant depression', which can ensure lifelong patients and profits. This is a massive psychiatric drug failure. It's not that the patient is resistant.

But for once, let's call a spade a spade. The drugs have failed. Treatment has failed, pouring more money into failure while concealing this with claims that patients and children are treatment resistant, and now maintenance electroshock, or some other brain intervention, is needed cannot continue. Add this to the conflicts of interest in the industry and you can see why Australia is facing the damage from the profit-driven drug industry that has more attention on filling their coffers than helping patients in need.

CCHR is actually justifiably enraged by the abusive treatments and lack of holistic care. CCHR has been documenting Australia's mental health decline since 1974, when it was first

established here in Australia, and back then, we had to fight just for the right to informed consent, let alone the right to be not subject to such damaging treatments as deep sleep treatment, which is thankfully now banned. But the wake-up call has been around.

Numerous government inquiries have been held, abuse is uncovered, and recommendations made. Yet here we are again today hearing the same song, perhaps with a different tune, which of course is more funding for the same in too many cases. Now is the chance to really do something about it, and this can be a totally different inquiry to the past and really make a difference.

The Australian public needs this inquiry to name and define results needed, especially in terms of numbers of patients recovered and leading fulfilling lives, and make the funds and practices accountable for meeting those stated goals and results. To do anything other is just reinforcing what can only be labelled as consumer fraud for the last whatever - how many decades it is.

So we would like the Commission to tell patients the truth. That there's no test to confirm any psychiatric diagnosis, to eliminate the harmful treatments and the conflicts of interest that have driven - driven them, and we would like to see true mental health for everybody, and for our children specifically, for our future generation. And there are so many alternatives, and it is about finding the cause of the problem for each person, which can vary greatly.

There isn't a blanket, you know - a pill for every ill. What is happening with that person, what do they need, and please let's redirect the funding into the areas that genuinely help people and make them accountable for results.

PROF KING: Thank you for that. Can I pick up actually on your last point? Because that exactly feeds into the first question that I had.

MS WILKINS: Sure.

PROF KING: So for people who feel they need assistance - - -

MS WILKINS: Yes, and they do.

PROF KING: - - - and you're saying that - and do need assistance.

MS WILKINS: Yes.

PROF KING: And the medication, the clinical approach is not the right approach. Do you see the funding then going into the sort of psychosocial supports, whether that's the things we heard about earlier today, such as exercise interactions, housing support, those sort of - is that where you would see the system needs to focus?

MS WILKINS: When somebody contacts us, because people can become extremely distressed, anxiety, depression, they can act, you know, they can act psychotic. There's no dispute about that. The thing that needs to be done is finding the cause for each problem, and we reckon when the first thing that somebody does is actually go to their GP. Go to their GP and get a thorough, full physical check out, because it's very well known, and medical studies

have shown, that if someone has a physical condition it can manifest as a so-called psychiatric symptom. They're actually not mentally ill; they have a physical condition.

So that's one of the key things, and as regards to funding of that, of course, GPs have - they have their 10 minute visit, they've got their long visit, they've got all sorts of those things. But if this is done and the person's helped, and they do have a physical condition, then they're not going into the system, so the funding will not be necessary. And yes, of course, at the start, as everybody goes to see a GP initially, there will be an increase in the amount of money required.

But that will obviously lessen, because we want people to be back in the community, happy and healthy and productive and, you know, kids doing well at school, and that's actually the result that - you know, that has to occur. But it doesn't occur when children are put on psychiatric drugs. You can't mask it. Find out what's happening with that child. You know, are they behind in school because they need tutoring. Are they being bullied at home? You know, are people homeless. The need somewhere to say.

You know, there's so many things where the funding can be redirected, because we do need to spend the funding. But let's make sure it's accountable.

PROF KING: Okay. So recognise that there's situations where mental health may be related to a physical condition.

MS WILKINS: Yes.

PROF KING: It may be related to things like financial stress.

MS WILKINS: Yes.

PROF KING: But as the example earlier today of one person who had suffered from significant trauma, and I'm not sure if you were here. She had suffered from sexual abuse. So that's a situation where it's clearly the sort of support needed, you know, it's not just a physical condition, as such.

MS WILKINS: No, no, absolutely not.

PROF KING: So what would you see as being the services for that sort of - for someone who has suffered from many years of sexual abuse, possibly within the (indistinct).

MS WILKINS: Yes. I'm not a clinician.

PROF KING: No, no. I understand. I understand.

MS WILKINS: And I'm not a medical doctor, so I really - you know, we actually, as a - CCHR does not recommend any specific form of treatment, because I'm not a doctor. I cannot give medical advice, and it really is - I mean, it's about informed choice. You know, if one patient may want to, I don't know, you know, see somebody and someone wants to see somebody else, and the thing is, the funding like - you know, the services that are provided, are they accountable? Are the results working?

You know, it might be that someone needs to - you know, medical doctors recommend that good sleep, good diet, and exercise. So amongst that, you know, you might need - you would need dieticians. You know, you might need - maybe someone is depressed because they've got a physical condition and they can't exercise. So, you know what I mean? You might need exercise specialists and - you know, there are a lot of facilities and a lot of things that are going to be needed.

If someone is chronically depressed because their finances are a mess, and I don't know, if mine were a mess, I wouldn't - you know what I mean?

PROF KING: Yes.

MS WILKINS: So like, help them with their finances. What is going on for each person, and then if you do that, then they return to society in better shape, without having been damaged by electroshock, and then they can no longer work and they have memory loss, and you know, the kids - parents are looking at their children going, I don't know why my son is no longer active, and, you know, he sits in the corner and, you know, I've lost my son because he's on Ritalin, for example.

And the side-effects of the drugs, you know, need to very much be looked at. You know, antipsychotics can cause massive weight gain. So then again, that puts more pressure on the medical system, and we really do want, as I know, that we want everybody to return to good health. You know, we experience that. I'm fortunately extremely lucky, and you know, to hear, you know, day in, day out of the abuse that people are experiencing in the mental health system, it drives me, because it is really not okay.

PROF KING: Okay, thank you.

MS WILKINS: Yes.

MS ABRAMSON: I just wanted to understand, Ms Wilkins, the point that you made about the Mental Health Act?

MS WILKINS: Yes.

MS ABRAMSON: You said the Western Australian Act had criminal provisions. Were you talking about when treatment is provided by people within a mental health facility? Is that what you (indistinct)?

MS WILKINS: I mentioned that it's the only Mental Health Act in the country that actually has a criminal finding in it for not reporting sexual abuse of patient. It's the only one. The laws, I'm sure you're probably aware of, because you're a lawyer, the laws vary across the country, and they do. Psychosurgery, cutting and burning the brain, completely illegal in NSW and the Northern Territory. Banned for children under 16 in Western Australia and South Australia. Queensland banned the cutting and burning of the brain for all ages, all ages. And Victoria, there are no bans at all and they're performing it.

The NSW government actually conducted an inquiry into the, you know, effectiveness and, you know, safety and effectiveness of psychosurgery when the Mental Health Act was under review here. And the end result of that was, there is no evidence to prove that it's safe and effective, and yet it's still being done. So if people are actually helped with the cause of their problem, then they will - and I mean, sometimes it's severe. Sometimes you won't find the physical condition in the first go. And, you know, it can be a myriad of problems.

But we really do, because we're talking about people's lives, and their families. And the abusive treatments are not working, because the inquiries continue and you can't have accountability in an inquiry if you don't look at what is actually being done. Just as an analogy, and this is not to make less of the desperation that people are under, because I hear it every day, and all my volunteers hear it every day.

If you're running a business and you keep throwing money at it, and it's not working, you want to look at what are the people in that industry doing? You know, what are they doing? Are the treatments effective? What is actually being given to the person, as an actual - you know, as the reason why the system keeps failing. Because we have, as you would know, had so many inquiries. I don't know if you recall the Royal Commission into Deep Sleep Therapy.

PROF KING: Yes.

MS WILKINS: That was an actual - you know, that was an inquiry. You know, and as a result, it was banned. But what was looked at was what was being done in the facility. And, you know, if you want to - if we all want happy and healthy kids and happy and healthy families, then we have to find the cause of the problem for each person. We have to get rid of the harmful abuse and the psychiatric drugs with their potentially dangerous side-effects.

Patients and consumers need to be educated. There needs to be warnings on boxes, you know, to warn that - of the - at least of the suicidal reactions, the fact that they can report side-effects. We did a survey at one point, and nobody - most people didn't know who the Therapeutic Goods Administration was, let alone to know that they could report a side-effect. And these are the areas, and then, from that account - - -

MS ABRAMSON: Excuse me, can I just - we're very mindful of time.

MS WILKINS: Sure. Not a problem. Not a problem at all. Yes.

PROF KING: Thank you very much.

MS WILKINS: You're welcome.

MS ABRAMSON: Thank you very much.

MS WILKINS: Thank you very much.

MS ABRAMSON: Sorry, we just had a time constraint.

MS WILKINS: Completely fine. Very appreciated.

PROF KING: Next, Andrew Pryor. So if you can state your name, any group that you're representing, if you're representing a group, and any introductory remarks that you like to make, for the transcript.

MR PRYOR: Great, thank you. Yes, my name is Andrew Prior. So I'm here as an individual. So I'm involved with several organisations, but I'm not speaking for them, and I don't represent them today. So just to cover them off; so I'm really here as a carer for my daughter, who's been through a journey, and giving you some of my reflections on that journey with her through the mental health - various mental health services, and also as a partner with my wife having been - also been through their own challenges. So in terms of organisations that I'm involved with that I'm not representing today, so I'm on the board of Flourish Australia, I'm on the board of Mental Health Carers New South Wales, who was represented yesterday, and I also do work part-time with headspace, two days a week, over at western Sydney in three headspace sites. So happy to take questions in relation to those, but I won't be speaking for them so - - -

PROF KING: No, understand.

MR PRYOR: So I guess in terms of my journey, I guess I was - like, my background is a corporate career, so for 25 or 30 years. I had the opportunity about 18 months ago with changes there to basically focus my life and this phase of my life on not for profit mental health, hence the organisations I'm involved in. I'm a graduate of Australian Institute of Company Directors and I'm on the boards I've mentioned. But what really got me there is through the journey with my daughter and realising what needs are out there in terms of mental health, and so really I welcome the Productivity Commission. I agree with others that have said it's a once in a lifetime generational opportunity for change.

And I - listening to as much as I could yesterday, in terms of some of the people presenting and thank you for the public hearings. So I was driving around western Sydney through all the headspace sites. So I listened to it where I could and it was a good - really great the live streaming, worked very well, and obviously I spent time listening to people today and there's been some fantastic presentations. So thank you for the opportunity of having these open forums. So with my daughter, she's had lots of challenges through her teenage years, came to a head during HSC year, as they tend to, and then she's sort of - in a period of three years following that, she was in and out of hospitals for about cumulative six months. Public systems, private hospital systems, which I'll get to in a minute.

In addition, with my wife she's just celebrated her 20 year anniversary of weekly psychologist sessions, working her through childhood trauma and I've been on that journey with her as well. So through these - with my daughter, we've seen plenty of different services. So I guess reflecting on what some people have said today and just my thoughts on some of the - I've read through the report, and also heard what a lot of people have got to say and I thought I would just throw my two cents worth in. With my daughter, she's currently on 12 different medications. She's been out of hospital for 18 months, and so that's administered to her daily. And one of those is Clozapine, which was mentioned earlier, which is obviously one of the most controlled drugs around and I know it has had side effects, that was just mentioned, but for her that's sort of probably been a life saver.

So - and that's made such a difference with her not having her psychotic symptoms, and being able to get back to some sort of life, some fulfilling life, what that means to her. So she has, with her medication, put on about 50 kilograms, on that. They say on average you put on about 12 kilograms. From what I understand, people in the know, it can be anywhere between zero and 50. She's at the higher end, and as a parent you'd be - you're concerned in relation to the physical consequences of that and from what I understand from people in the know, they're in researching, that significant side effect there's no - no solution in sight for that, from what I understand, for the next range of drugs that are coming through.

So these are the current drugs that they're doing and all - they all have these significant side effects which then has a double impact on the physical side effects as well. So in terms of - I just want to reflect on a couple of things in the draft report. Firstly, funding. Look, I think the five year funding is absolutely fundamental. You know, obviously at the moment it's one year, two year, three year funding at very best. You know, I come from a corporate background. That just means these organisations can't be strategic, short, medium term, it's always too short term thinking. So I think that's a really important one, and secondly it also, from what I can see, is a major flow on impact to attracting the right people into these services and retaining them when they have alternatives at the moment where - which isn't contract based.

So I think that's quite fundamental and I applaud that. Secondly, in terms of the MBS I note, I think, in the report that currently the proposal is to go from 10 to 20, I guess, MBS supported visits. The first thing I would say is I applaud the - the latest announcement of the eating disorders which is for 40 sessions a year. I'm not sure the clinical evidence or medical base for you recommending 20. To me people that have complex needs need to be engaged on a weekly basis. So I applaud 40 and I'm not sure where 20 came from. So I would think people with complex needs such as trauma, disassociation, and I really put my - you know, I'm really thankful for Scarlett earlier today talking about some of these complex issues.

So I really - it's fantastic that we've made progress with MBS on eating disorders, but that shouldn't stop there and I'm not sure why you're recommending 20. So I think we should be focusing on the weekly basis, so 40, when you exclude other things, you'll probably get there. So that would be my proposal and as people have said today that doesn't cover the full cost anyway, that just means you're getting more back. So in terms of scale, one reflection I have and I note the CEO of headspace, Jason, has quoted that in terms of the 110 headspace sites currently unbelievably there's 70 different organisations running those headspace sites. So from my perspective again from a corporate background, you know, I guess this is a lack of scale in terms of people being able to - you know, you don't have the scale to be able to manage these locations, which impacts all sorts of things, you know, collaboration, learning, best practice et cetera.

So to me it's fragmented and so I think - you know, I think scale brings a lot of things. It also enables things like effective youth engagement and family friends engagement which I'm involved with headspace, and these are quite critical and the more scale people can have the more they're likely to be involved with these types of things. Also they play a critical role in the (indistinct) model for headspace. So as I said I'm a big supporter, but I think these should be adopted much more broadly in terms of services and programs to ensure that there's a youth

voice where it's youth related service, and likewise that there's family and care engagement where - where possible, and I'm not sure that was - came through in the report.

In terms of collaboration between CMOs, rather than competitions, I think the NDIS seems to have had an impact on people being more competitive as well as the whole tender process through the PHNs. I think in terms of collaboration PIR, which is now defunct as you know, was a good example of collaboration and people working together and I think there's advantages in doing that. So again - - -

PROF KING: Sorry, just for the transcript PIR is - - -

MR PRYOR: Yes, whatever it was called, yes.

PROF KING: Partners in Recovery. It's all right.

MR PRYOR: (Indistinct) program. Forgotten it already, because it's been defunct. So - but that's a good example. But I think part of collaboration is people also - organisations focusing on their strengths. So for instance I think you mentioned in your report ReachOut as having a fantastic digital platform, these type of things. So - and headspace obviously having a good physical footprint and a well known brand, you know, recognition brand, and then someone like Flourish, you know, having a good reputation over many years of, you know - you know, people with complexity, giving employment and having a fantastic peer workforce. So I think there's a whole lot of collaboration that can be - which I don't think really came through in the report as well.

So NDIS, I'm not sure how that works with scope, but I think those mental health challenges have been pretty well documented, including permanency but that's a continuing challenge which I know a separate analysis is being worked on. In terms of co-design, I thank and applaud Irene from Being yesterday bringing this to your attention. Obviously this should be fully embedded in this process and fully embedded in - and I guess this is a component of that, but this isn't co-design, and I guess trying to work through what that means for a process but also rolling out co-design elements in terms of programs going forward as well and again I think that could be better put through this process. So - and in terms of funding also co-design through peak bodies, such as Being and Mental Health Carers New South Wales is also something that we need to be focused more on, just make sure we're training people with what co-design is about.

So I support everything that Jonathan said yesterday in terms of carers and the carers involvement in the journey. I won't go back over that because I think Jonathan has covered that, but I thank Jonathan and Peta for presenting yesterday, and I also support in the draft report a lot of the focus is on navigation and pathways. This is a clear problem everywhere, and I guess in terms of - yes, so some of the recommendations that makes sense to me. In terms of early intervention, obviously I have involvement with headspace with the early psychosis program, and that's been piloted for many years which I think Orygen touched on yesterday and Roger touched on earlier. So, one of the successes, and evidence based program is that it's the breadth of the program which means it's successful. So, but it's in pilot phase, too, and it needs to be rolled out. It's a tragedy we've only got three early psychosis programs within the population of Sydney. It's a tragedy there's not any in Southwestern Sydney. So there's funding

for a pilot, but there's no funding for the next phase of being rolled out. So we've got a successful program, let's roll it out. And I think, also, yeah, the fact Southwestern Sydney isn't covered with this type of thing is just, in my view, unbelievable.

So, I guess from my perspective, being involved in the early psychosis program, it's what's next, and I think what's been touched on by Scarlett and with Professor Roger Gurr earlier today in terms of trauma, is a very – you know, again, the fact it wasn't a big highlight in your report, I think Scarlett said three times, she was able to count that, but to me, trauma and childhood trauma is the next phase. So what specific programs are we running that actually focusses on trauma, and so actually, from the start like we did with early psychosis program, it's a ten year program – it's a ten year timeframe to get that up and running, but what's next.

Likewise, borderline personality disorder. Some specific, you know – you know, as you know there's a high level of self-harm with people that identify with borderline personality disorder, so can we have specific programs that are being developed, evidence-based, that can actually focus on the next ones after psychosis and after trauma. So, also, I just wanted to ensure, in terms of, obviously, there's been touched on about trauma informed services, and training is an important part of that. We also just want to touch on your focuses on the 0-3, I know you've touched on that today, in terms of the 0-3s, and the screening programs.

I just want to bring to your attention, and make sure you've seen, that there was the Murdoch Children's Research Institute, had a really fantastic report, which as presented out in Blacktown, in relation to 1,000 days from inception. So if you have not had the chance to read that, that is a really rounded report. I'm happy to send it through if you haven't got that. A couple of other things, I fully support what's been recommended in terms of IPS. I know that was a core part of the report. I've seen that in place at both headspace Penrith, but also with the early psychosis program, and so the rollover of that, I agree, would be fantastic.

I also support the priority population focuses, in particular on barrier, whether it's contra-sensitive services, LGBTQI was covered earlier today, Aboriginal/Torres Strait Islanders – all of these make sense. We should be focusing, and we should be prioritising funding on these focus areas. Data capture, I totally agree with what's been said. I think headspace leads the way in capturing LGBTQI communities. Most services don't, so I support exactly what they said earlier today. Just a couple of reflections, if I can, on hospitals, emergency departments - - -

MS ABRAMSON: (Indistinct).

MR PRYOR: Okay, yes. So, that's why I told you. I'll cover off in terms of hospitals, the public and private hospital system we've been to both. The public hospital systems are a bit like holding pens. There's no programs embedded within these acute walls at all to help people to develop their skills, and there's no real psychological treatment that's happening in these acute walls, in my experience. The private system, there are some – more so, some programs that are there, but I won't spend time on that. But TMSETC, we've had experience with all those, and these need to be tried, because it might work for some people.

Emergency departments, can I just touch on this briefly, is that we've spent an hour in there, never less than four hours. These need to be – emergency departments, and I agree with some

of the reports about having alternatives to that, and also have places, safe places, to be there. And that's why I agree with all of that in the report. The only thing is, the proportion of staffing at the moment, in these wards, relative to the people that are presenting with mental health challenges or illnesses, is not right. And so you're waiting for one registrar, and that's why you can be waiting eight hours. And so you'll be the first person there, the last person to leave.

PROF KING: Can we – I know we want to ask a couple of questions, and - - -

MR PRYOR: Okay, yeah, that's fine. So, I think my last comment is, we need to get an appropriate and equitable share of health funding. So I think we need increased funding, and we need to be more proportionate to physical health funding, and numbers need to be in billions, not in hundreds of millions. So, yep.

PROF KING: Can I just run on, sort of, to headspace collaboration. I just want to make sure I understand your point. So, you said there's 70 different organisations run 120 headspace sites.

MR PRYOR: 110, yes. So that's the lead agents. The lead agencies, yes.

PROF KING: Yes. But you're worried about lack of scale fragmentation. My understanding of those is that headspace is a franchise model, so – in the sense, you know, it would be like saying, any other franchise is run by a whole lot of different people, but it's guided very strongly by a central office. So I want to make sure I understand the headspace model, because we've heard the exact opposite, that it's not fragmented enough, that it isn't response to local needs, has been one of the things that was put to us. So, that's the first one. Secondly, when you're talking about collaboration, how do you see that working? And again, perhaps using your headspace experience. So they're my two.

MR PRYOR: Yes. I'd say, and referring to scale is that rather than having on lead agency looking after one side, that you may be looking after regional areas, and I've seen that work within Western Sydney, where it's got multiple places, and so therefore you find that people are learning from each other in terms of how they're engaging with the community and later.

PROF KING: Okay.

MR PRYOR: And also, you touched on it earlier today, I would also say the consortium is also different. I know we were talking about Bondi earlier today, but the consortium cases is what's also tailored towards what's appropriate for each of the headspace sites and their locations. So that's what makes it different, and so therefore you might be engaging in very different consortium partners in Western Sydney than you may be at Bondi. And so, the consortium process does work, and that's the model that's there, but the model doesn't tell you who your consortium partners are. So that's up to you to engage within that. So I think we can be – I guess my point on collaboration isn't so much within that headspace environment. My point on that is more about scale, and just making sure that we just have best practice by leveraging off having scale and having lead agencies that are not just looking after one particular site.

PROF KING: Okay, thank you. Julie?

MS ABRAMSON: No, I don't have anything.

PROF KING: Great. Thank you very much.

MR PRYOR: Thank you.

PROF KING: Now, I don't have the details of the next person.

MS ABRAMSON: Is there anybody else who'd like to give evidence whilst we're here? You need to do it from the table, and you'll need to announce who you are and where you're from.

PROF KING: We'll just say, we do have one other person to go.

MS DUCASSE: I'd like to, but I'll be really quick.

PROF KING: Yes.

MS DUCASSE: My name is Libby Ducasse, and I'm in Sydney, but I'm born and bred in Adelaide. I followed my journey with my elder sister who had a breakdown, they called it back in those days. She's ten years older than me, and I followed her psychiatric journey since I was 8 years old, which has been really heartbreaking. I could go over different stories that I could tell you about the number of psychiatrists that she's had. I've listened to the stories that have been told today, about her coming out of a psychiatric ward a lot worse than when she first entered. The level of care that she had, the different drugs that she had, the side effects, committing suicide, attempting the committing suicide.

But I wanted to take this opportunity to just say something else right now: I really appreciate that you two are here, at this time, and this place, and you have a chance to make a big difference, a mark on Australia, as of today. I really believe in that different primal effect that that lady mentioned with the dark hair, that cared for her mother, about we need a chance in Australia. If a psychiatric treatment is working, where is the results? I didn't see it on my sister. I haven't seen it.

A friend of mine recently had a break up, which was really nasty, and she went to see a psychiatrist. She told me, she's not going back, because it just made her feel worse. The tablets made her feel so weird, she couldn't feel anything. These are not the results that we want. If I had a choice for my sister, I would have had her in a very calm environment to get over this initial stress; she was only 18 at the time, and I think having that different primal effect, having been able to have proper care. If they go to a psychiatric ward, like this gentleman who just spoke, said there is only one registrar. I've experienced that with her. My whole family, we had to wait for hours, and like, that was like eight years ago. I don't know what it's like now, but you guys can make the change.

You can make a difference on the whole of Australia, like with Shelley talking about how in, I think it was Melbourne, there's no thing on someone being harmed on mental health. You can change it. Not just for your families or your own self personal integrity that you've been given this great honour, but you can do it for all Australians, all the children. Like it's very hard to have an early intervention program and have a checklist, because as a parent, I'm a mum, we

all know that we've got different children. Some of them are - like I've got five sisters, my mum and dad had six girls, we are all different. I was very chatty and lively, one was a total book reader, you know, quite quiet, we are all different, but by you guys just making the right decisions, putting some laws in place that go right around for Australia, going in yourself and looking for yourself. Not just sitting behind a desk, go into that psychiatric home, just have a look - have a look and see.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you very much. Could I now - we would like to close - - -

MS DUCASSE: Did you want a question?

MS ABRAMSON: No.

MS DUCASSE: Sorry, I will go back to my seat then.

MS ABRAMSON: We were actually going to close the hearing, because we want to take one witness in camera. So if we can ask people to leave the room and after that we will close the proceedings for the day. So if you would be kind enough to leave so that we can - - -

PROF KING: Take in camera. Thank you.

MS ABRAMSON: If we can also cut the live stream, please. Can I just confirm if you didn't mind saying your name for the transcript. You don't have to.

PROF KING: It's up to you.

MS BARIT: No, that's fine.

MS ABRAMSON: That's fine?

MS BARIT: Yes. My name is Deborah Barit, and I want to cover a couple of points. One is a personal experience and one is a comment from my professional experience. I will start with my personal experience. In May this year my 30 year old daughter committed suicide. This was her seventh attempt. Now, this isn't who she was. I want to put a bit of background in.

My daughter was incredibly bright. At 3 she learned to - she taught herself to read and at 5 she was reading Roald Dahl novels. Then she got into the opportunity class and in Grade 5 she developed diabetes, Type 1 diabetes. She was very good about it, she controlled her own blood sugars, et cetera. When she finished primary school she was given opportunities in terms of both winning scholarships to private schools and getting into selective schools. She finished high school with a UAI of 98.7.

Late - it probably started when she was 16, but I misunderstood it as going through her teenage rebellion years. She started self-harming only in terms of her diabetes. So she wasn't looking after her diet, et cetera, and she explained to me the diabetes had deprived her of her childhood. When she finished school she went to university and for the first time she couldn't cope, and

for the first time in her whole life she failed a subject. We talked about it and she decided to take some time out and started some really dangerous behaviours, which surprised me; partying, drinking. No, she didn't take drugs except medication.

The next year we discussed the fact that she should have a year off and give herself time. We talked about getting some counselling, but her opinion was she should have her own - that she should be capable of sorting out her own life, and then went off the rails. She quit her job and she went overseas and disappeared in the sense that there was virtually no contact and the only way I could track her was by the credit card bills that came in for me to pay.

When she came back from overseas she developed a whole new personality. She became aggressive, rude, inconsiderate and there was nothing I could do. Again we discussed her getting some help, but, no, she refused. The GP was seeing her regularly talking to her, and one day I had this terrible sense that she was going to attempt suicide. I can't explain it. It was just this awful sense. I rang my GP and I actually asked her about what's it called, having her committed. My GP explained - said to me I was overreacting because my daughter could put on a really good act.

Two weeks later she made her first attempt. She ended up in hospital and we sat in the emergency department for five hours. Having taken an overdose I didn't know if she was going to get worse, if they wouldn't get to her in time. So I was fortunate I have a couple of nephews who are doctors. They're interstate. I rang one of them because that's the only way I could find out that it was okay, she was sitting there and she wanted to go home.

Anyway they did admit her and she was put in the observation ward, which was a nightmare of a place. There were no windows and the whole thing was open, it was mixed, and the staff were all locked into a glass cage I suppose. Anyway they were going to let her out the next day because it hadn't been a serious attempt. My GP convinced them to keep her for a couple of days just so we could get respite care. She came out, there was no follow up except for - what it's called - the crisis team.

PROF KING: Yes, the CAT teams or - yes.

MS BARIT: My experience with the crisis team was very similar to the lady who was talking about her mother. The crisis team came to see her, and my daughter explained to them that she was fine; there was nothing wrong with her and as a result, they decided there was no need to follow up and when I talked to them - because in those days I had no idea - they informed me that the best thing I could do was get a counsellor and cope.

A couple of years later my daughter dropped in and out of university, she did some work, she did another overdose, and each time she did it - and this time it was a different hospital. We went there, they checked her out, the psychiatrist talked to her, I wasn't spoken to because she was over 18; nothing, and we were told that as soon as her blood pressure came down and the heart beat came down, she could be released and she was, at midnight they discharged her.

These sort of experiences I found really difficult. We had counsellors, given the nature of who my daughter was, who had no idea and so she started playing games with counsellors, with psychiatrists, because she could have fun because they treated her as a half-wit. So, she was

several steps ahead of each and every one of them, which wasn't very productive, but they didn't want to know who she was and that was a result of continuing, and over a period of time she upped the anti each time she made a suicide attempt.

Each time it was a bit more serious and each time it was terrifying, but there was no follow-up. I was told, 'Hey, it's not so bad, it's okay,' and I thought, 'No, it's not okay.' I begged for help and the information I was given was, 'It's too complex, it's too long-term.'

Even contacting private psychologists, they rejected it because it involved the family. It was too complex, they didn't want to take it on - social workers, and so we continued and each time she upped the anti a bit more, and in 2015, by this stage, apart from her diabetic medication, she was on a whole series of different medications including Seroquel.

Now, I'm sure there was a piece of paper that said, but the fact that it makes you hungry all the time, interacted with everything about being a Type I diabetic. Her blood sugars went out of control and she took more and more insulin which, as most people know, makes them aggressive because it's got testosterone and the more you take, the more it becomes dangerous.

Anyway, the psychiatrist at the time told her, because she was anxious, just to take an extra Seroquel, and so she did and she got more anxious and she took another one, and she took another one, and she ended up with full-blown psychosis where she tried to kill her sister and so, she had to go into hospital and she was in a - because she'd been committed, and she didn't know who I was, she didn't know who anybody was. She was totally out of control. They had to put her away because she thought she lived on another planet.

So after that, we put her in a private but the doctor hadn't told her that you might be able to take one more Seroquel, but because of the anxiety she just kept taking it and no one said you were going to get a psychosis. And during all this time, every time we saw a different psychiatrist, my daughter got a different diagnosis and therefore, different medications and different treatments which turned out to be inappropriate. And in between all this, I couldn't get her out of bed. She went to bed for about four years, I mean literally.

So after this episode we got more help and after the psychosis they gave her two new diagnoses. The others were not appropriate and, as a result, she got new medication.

PROF KING: Can I just clarify; was she being taken off the medications or were they just adding more and more medications?

MS BARIT: Some of the medications were removed and others were upped.

PROF KING: Yes.

MS BARIT: As a result of her psychotic episode, my other daughter had to leave home because it was - she had to move out because it was no longer safe to leave them together. I don't know that people understand how the family was destroyed, and I was still told it was just too complex.

Time went on and we got someone really good. This was a private service who came in and actually got my daughter out of bed; literally, and got her back into a social environment and got her to start going to TAFE to do her higher school certificate.

PROF KING: This was a psychiatrist?

MS BARIT: Pardon?

PROF KING: The person who you're talking about now, is that a psychiatrist who did this?

MS BARIT: It was a psychiatric physiotherapist; and convinced her to go back to TAFE - - -

PROF KING: Yes.

MS BARIT: Not that she needed to do her higher school certificate again, as you would understand, but to get her into a routine.

PROF KING: No; interaction, yes.

MS BARIT: So my daughter went to it, but having done all the subjects that she'd wanted to do, she took up things like advanced maths and chemistry, which she'd never done and she did really well in that too.

PROF KING: Yes.

MS BARIT: So again, she decided to do physiotherapy but she was unstable again, and so it came and went. She was finally diagnosed with body dysmorphia and bipolar too, and finally, we stopped using the services or the hospitals around us because in her many dealings with lots of psychiatrists and psychologists, she'd actually come across one she liked.

However, they didn't practice in Sydney, so she connected to that one that was in a country area, but in a city-country area, and she used to commute two hours one way because she trusted him, and we sent her to the hospital where he could look after her.

PROF KING: To practice, yes.

MS BARIT: It was the best positive thing that had happened. He didn't treat her like a moron; he didn't treat her like a medical - like, a condition, if you know what I mean; a mental case.

PROF KING: Yes.

MS BARIT: He treated her like a human being and an intelligent human being and she really started to improve; and there was hope - for the first time in 10 years there was hope. She actually moved out of home at the age of 29 and moved down there and started to develop a life. She enrolled at Sydney Uni and she'd started doing the study she'd always wanted to do, which was English literature.

And everything was going okay and then, early this year, she started to actually reconnect with her friends, see people. When it was her birthday last year, which was in December, she turned 30. She had a party. We went down for it and the first greeting she gave me was, 'Mum, we made it.' You've got no idea what that meant because for most of her life I didn't think she'd get to 25.

The beginning of this year she went to visit a friend in Canberra. She had a terrible accident. They were walking, she was carrying the friend's baby, she fell and broke her ankle severely. She was rushed to hospital to be operated on and when she got there, she explained; a) I'm a Type I diabetic; b) I've got osteopenia. For those who don't know, it's brittle bone.

PROF KING: Yes.

MS BARIT: They operated and they tried to get her out of hospital on the third day, as soon as she could put her foot down. So I rang up and said, 'Now, this is nowhere what a Type I diabetic, what it means in terms of healing.'

PROF KING: Yes.

MS BARIT: She lived on her own. She had stairs; so to get into her building to get to her place. So they gave us an extra day and from that, I'd kept private insurance for her, I got her into a rehab hospital near where she lived for seven days and then, they sent her home.

No services provided because a) you don't get seen for six weeks. She got an orthopaedic surgeon who specialised in ankles who was a sub-specialist in it and she did absolutely everything she was told, and after six weeks, maybe seven, despite having osteopenia and despite being a Type I diabetic, she was told she could put her foot down, she could start putting weight on her foot.

So she did. All the thing fell apart. She was in excruciating pain. She took herself to hospital, and when she got there, she was told to stay there. They had to remove the whole thing.

PROF KING: Yes.

MS BARIT: Right? So there she was in hospital. She explained to the doctor, the nurse, that she was a Type I diabetic blah blah blah and she had a pump - you know, an insulin pump.

PROF KING: Yes.

MS ABRAMSON: Yes, absolutely.

MS BARIT: In the middle of the night the pump stopped working. So she called over the nurse and explained that she was a Type I diabetic, that she was going to be first on the list, that her blood sugars were rising; the pump wasn't working, and the nurse said to her - and she asked to speak to someone in endocrinology - the nurse informed her that there was no need for any of this because they'll give her four units, short acting insulin, before they put her into the operating theatre.

She tried to explain that, you know, previously she'd had an infusion and saline, but she was told it wasn't necessary, and she had to take her blood sugars every hour and they keep going up and up.

PROF KING: Yes.

MS BARIT: So by the time the blood sugars hit 15 - I assume you understand what 15 means?

PROF KING: I understand that's very high, yes.

MS BARIT: Pardon?

PROF KING: I understand it's very high.

MS BARIT: Well, it's ketoacidosis territory.

PROF KING: Yes.

MS BARIT: She called the nurse again, and the nurse told her exactly the same thing. Then, she rang me, as I was leaving to get on the train to go and stay with her, and I rang them and I talked to another nurse and I explained it and all that, and I told the nurse I wanted a review and I wasn't happy with the treatment, at which stage, the nurse replied, 'I'm sorry to hear you're not satisfied. I will go and tell the other nurse.' Went off to tell the other nurse and the other nurse said, 'Don't worry, we'll give her four units,' at which stage her blood sugars were 17.

So she screamed the place down and an intern from endocrinology turned up, followed by the registrar, followed by the consultant, and by the time I got there she had a huge sign on her bed describing diabetes and what ketoacidosis is; a huge sheet so the staff - - -

PROF KING: Could understand.

MS BARIT: And i don't think diabetes is a particularly uncommon condition.

PROF KING: No; disease.

MS BARIT: So it was touch and go between, hey, they would operate later or she'd end up in ICU. That was the beginning of a whole series of disasters. So she had that op and the next one was an external fixation, which looked like something out of the dialects of the Doctor Who. Then, of course, there were complications with the diabetes. Then, there was an infection, so it had to be operated again.

PROF KING: Again.

MS BARIT: Then, the contraption shifted. So between January and April she'd had five surgeries. She'd asked for help but was told the only services, like, transport - because she couldn't get anywhere - - -

PROF KING: Yes.

MS BARIT: Were only for the aged, 'Sorry.' That's what the social worker said and said she'd just have to fend for herself and sent her home with the tube for - what's it called? Antibiotics.

PROF KING: A drip, yes.

MS BARIT: So if a nurse had to come in daily to change that and to - - -

MS ABRAMSON: IV antibiotics.

PROF KING: For IV, yes.

MS BARIT: Pardon?

MS ABRAMSON: Was it IV antibiotics?

MS BARIT: Yes. Sorry, I can't - - -

PROF KING: No, no.

MS ABRAMSON: No, that's fine.

MS BARIT: Anyway, she started really struggling. I was commuting twice a week because I still work. I was financially supporting her significantly.

PROF KING: Yes.

MS BARIT: She started talking about suicide again and I said - because she'd had a monumental suicide attempt in 2015 where she was 13 days in intensive care and after that, two days on the ward, and they sent her home. She had pneumonia, she couldn't breathe, but the psych unit said it was okay. So then she'd almost died.

So I talked to her and said how'd she'd promised and, you know, got her GP involved who was now down there. Anyway, she came up, we talked, I wanted her to stay, but I was going in to stay for work and she couldn't stay because she was totally connected to, you know, having her dressings changed - - -

PROF KING: Yes, all down at the hospital now.

MS BARIT: And we had an arrangement that when I came back - it was my other daughter's and my birthday and we were going to go down and celebrate our birthdays with her, take her out. She rang me the day before. She'd been talking about how she'd realised how some of the things she worried about were unimportant, how she understood that she'd created some of her own problems and it was the first time in 12 years she'd had insight. It was, like, seeing my daughter come back.

So I rang her and the day before she said to me, 'And tell my sister I love her,' and that was the last words, because when we got there the next day, there was no answer. I got the agent, we

walked in and we found her. Those five operations and the fact that nobody - everybody listened, but nobody heard.

PROF KING: Yes.

MS BARIT: And I want to say a couple more things - - -

PROF KING: Yes; please.

MS BARIT: Because I didn't see the point of, you know, having an inquiry because there was no purpose to it. My daughter had a history of attempting suicide. It's not like they were going to go and say, 'Oh, we slipped up,' because it was the system; so I didn't.

But I do want to say one thing. In my professional life I am a trainer, I train people for job interviews and my area for expertise is training doctors for medical speciality interviews, and I've been doing that for 15 years, both, to get into specialties and consultants, and I can tell you that it isn't their fault. What it is is a total system of training hospital - the feedback and role modelling they give - that makes them incapable of hearing their patients.

PROF KING: Yes.

MS BARIT: Their whole training is memory based. It's model-based on problem, solution; based on evidence-based medicine; and the focus is solve a problem. Patient is a condition, you eliminate, you treat and you get rid of them; and in that process, they eliminate the person because the focus isn't to solve the condition, and that the way they get through medicine is through memory.

PROF KING: Yes.

MS BARIT: They have this ability for vast quantities of really complex information, but what's missing in that training is the application of it. That you can memorise it, but unless you apply it in an individual and adaptive circumstances, it has no value; you're not treating the patient, you're treating a medical condition.

PROF KING: Yes.

MS BARIT: The hospital system just exacerbates it because they're overworked, they've got no time, they've got all this stuff, and so the easiest way to do it is to follow that process. I've been training doctors for a long time; I've got enormous respect for them. But one of the things that they do admit, which I think is really important, is they're not 100 per cent present when they see patients.

By the time the patient's saying something to them, they're already writing their notes for the management plan and going to the next one, and it's not their fault in a sense that they have no time, but it can cause enormous problems for patients, and one of the things they do is they don't talk about their patients by name. They talk about them as 'the adenectomy, bed such and such'.

PROF KING: Yes, it becomes depersonalised.

MS BARIT: Pardon?

PROF KING: It becomes depersonalised.

MS BARIT: Yes, and the other thing is, the whole feedback system of how you progress becomes really destructive, because while it's intended to be balanced, it never is. It's always about, 'You've got to do better at this,' or, 'You've got to learn about that.' It is never about how much you've achieved. So as a result, they don't have any self-confidence. As a profession, they are probably the least confident of professions, and you can hear it in the language they often use. Does that surprise you?

PROF KING: Yes, it does; because I was thinking - - -

MS BARIT: No.

PROF KING: That the clinical culture, it's a very hierarchical culture.

MS BARIT: No, because if you spend your whole life only looking at what I haven't learnt, what I haven't achieved, what I'm not good enough, because that's your feedback, you have no basis on which to say, 'Look, at me, I've gotten to here', and it's something I learnt through my work.

PROF KING: Yes.

MS BARIT: I won't go into the role modelling that - it's very important, but they don't usually get trained. They don't know how to role model, supervise, so it's this continuous thing.

PROF KING: Yes.

MS ABRAMSON: We do have a little bit of a time constraint. I think we've got the room until 6.00

MS BARIT: Sorry, I will finish.

PROF KING: No, no.

MS ABRAMSON: No, I didn't want to hurry you up. It's just that we have some logistical things.

MS BARIT: No, that's fine. But one of the things that strikes me is because they are trained in such constraints that they don't have time to listen. They listen, but they don't hear, and I think, to me, that's one of the keys.

PROF KING: Yes.

MS BARIT: Because my daughter spent all that time telling each and every one of them. Right? And they all were there and she wasn't inarticulate, she could speak English. Do you know?

PROF KING: Yes, they're not listening to what she needs.

MS BARIT: No, they listen. What they didn't do was hear.

PROF KING: Hear; correct.

MS BARIT: And because it's process-driven, it isn't adapted. Predominantly after six weeks, everybody gets up and walks.

PROF KING: Yes.

MS BARIT: So that's my comment on that. I'm sorry I've taken so long.

PROF KING: No, no.

MS ABRAMSON: No, it matters a lot and it's very difficult; the story that you've told to us and it's very important to us.

PROF KING: Yes, it's very important.

MS ABRAMSON: And can I also say that the Commission is very sorry for your loss.

MS BARIT: Thank you.

PROF KING: Can I ask? Because what you've raised in an issue we haven't really dealt with in-depth so far, but I think we need to, which is that the clinical culture that you've discussed there at the end - because we talk about a consumer-centred mental health service.

MS BARIT: Yes, but - - -

PROF KING: But you can't have it if you don't have people hearing what the consumers are saying and - - -

MS BARIT: Yes. I don't like the word 'consumer'. You see I think consumer dehumanises.

PROF KING: Okay.

MS BARIT: 'Consumer' is like, you know, 'the human resources department'. Do you know what I mean? It depersonalises and people don't feel connected to it.

PROF KING: Interestingly, patient is usually viewed as worse.

MS BARIT: Yes.

PROF KING: So I'm not sure there's a good term of the persons.

MS BARIT: I think it's like branding. You know, to me branding is a corporate thing.

PROF KING: Yes.

MS ABRAMSON: Can we ask, where there any other - we've soon got to look at (indistinct). Is there anything else that you wanted to talk to us about?

MS BARIT: I want to add one more thing.

PROF KING: Please.

MS ABRAMSON: Sure.

MS BARIT: I have a background in disability. I worked in the Commonwealth disability services for at least 15 years. I worked with long-term unemployed, I trained people who are on the Work for the Dole scheme.

MS ABRAMSON: Yes; Job Active.

MS BARIT: Pardon?

MS ABRAMSON: I'm must talking about the programs. Yes, please, continue.

MS BARIT: So I have a reasonable background and understanding of services in terms of background and I couldn't (indistinct) my way through the system.

PROF KING: Yes, all right.

MS BARIT: That's all I'd like to add and I'm sorry to have taken so long.

PROF KING: No, no.

MS ABRAMSON: No, that's a very powerful testimony and we're very grateful because you sat through two days of hearing, and what you've said to us, the lived experience of people matters enormously to this inquiry.

PROF KING: Yes.

MS ABRAMSON: So thank you very much of giving us the privilege of listening to you.

PROF KING: Yes; to your story.

MS BARIT: Thank you for listening to me.

PROF KING: Thank you.

MS BARIT: I will put in my remarks about doctor training.

MS ABRAMSON: Thank you.

PROF KING: That would be fantastic because it is an issue that we have to understand and we have to grapple with.

MS BARIT: I think that is a big issue that the way doctors are trained, but more importantly, the pressure on them.

PROF KING: Yes.

MS ABRAMSON: Thank you very much.

PROF KING: Thank you very much.

MS BARIT: Thank you for listening.

PROF KING: Thank you.

MS ABRAMSON: So, Dr King, I think you can formally close the - - -

PROF KING: Well, I'll formally close the - - -

MS ABRAMSON: Adjourn the hearing - - -

PROF KING: Adjourn is the term. Yes, that's right.

MS ABRAMSON: Until next (indistinct).

PROF KING: Adjourn the hearings for today and we will reconvene on Thursday in Broken Hill.

MS ABRAMSON: Thank you.

PROF KING: Some of us will reconvene on Thursday in Broken Hill.

**MATTER ADJOURNED UNTIL
THURSDAY 28 NOVEMBER 2019**



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

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

TRANSCRIPT OF PROCEEDINGS

BROKEN HILL CIVIC CENTRE 31 CHLORIDE STREET, BROKEN HILL
ON THURSDAY 28 NOVEMBER 2019

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GLENDA BEESTON — TEACHER, WELLBEING PROGRAMS

PETER GOUGH — MAARI MA ABORIGINAL HEALTH CORPORATION

**VANESSA SMITH — BROKEN HILL COMMUNITY MENTAL HEALTH, DRUG
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**DES JONES — CHAIRPERSON MURDI PAAKI REGIONAL ASSEMBLY, MAARI
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VANESSA LATHAM — ROYAL FLYING DOCTOR SERVICE

EMMA OSMAN — ROYAL FLYING DOCTOR SERVICE

KAYELENE CROSSING — WARRA WARRA LEGAL SERVICE

DR RAMU NACHIAPPAN — GP

JO-ANNE COLE

PROF KING: So I'll get started. Good morning. Welcome to the public hearings of the Productivity Commission inquiry into mental health. My name is Stephen King and I'm the presiding commissioner on this inquiry. I'd like to begin today by acknowledging the traditional custodians of the land on which we meet today; the Barkandji people of the Barkandji nation. I would also like to pay my respects to Elders past, present and future.

The inquiry started with a reference from the Australian government in November 2018. The purpose of the inquiry is to present recommendations to government in May next year for reforming the mental health system. It's incredibly broad. Any of you who have had the pleasure of having looked at our draft report, which came out on October 31, we've a thousand two hundred and something pages and we know we haven't covered everything in there; we know there are gaps so, really quite interest in a wide ranging discussion today.

We've talked to representatives of Australian state territory governments, service providers, peak body's unions, academic researchers and individuals with an interest in the issues and held round tables throughout the inquiry. Most importantly, we have talked with consumers and carers, and if there are consumers and carers here then, thank you for attending.

We've released the issues patroned in January and we've talked to a range of organisations and have received 573 submissions since its release. We're grateful to the organisations and the individuals that have taken the time to prepare submissions and to appear at these hearings and, as I mentioned a couple of weeks ago, we released our draft report.

So the purpose of these hearings is to provide an opportunity for interested parties to provide comments and feedback on the draft report, facilitate public scrutiny of the Commission's work and to get feedback on the draft report. We like to conduct all hearings in a reasonably informal manner, but I remind participants that a full transcript is being taken. For this reason, as I said before, if you want to make a comment you have to be around the table because the black mics are just for the transcript. If you give a comment back there, it just ends up being a blur.

As I mentioned, by the way - well, as I haven't mentioned, but just a point. I don't expect everyone to have sort of said, 'Yes, I remember the recommendation.' If there's anywhere where you say, 'What did you do in this area?' just ask the question and between the three of us, I think we can probably remember every recommendation in there or, if not, take a pretty good guess.

MS ABRAMSON: Yes, should be.

PROF KING: I remember them all.

MS ABRAMSON: You remember thousands and thousands (indistinct).

PROF KING: No, no, just the wrecks. This is the eighth public hearing of this inquiry. Following this hearings, hearings will also be held in Rockhampton, Brisbane, Launceston and Adelaide - and Darwin I thought; yes, okay, it's missing on here.

We will then be working towards completing our final report having considered all the evidence presented in the hearings and submissions, as well as in other informal discussions.

But for those planning to lodge a public submission we vet feedback on the inquiry draft report. The closing date for submissions is 23 January 2020.

Can I by the way just encourage people, if you've got any thoughts following up today, just pop them in an email and send them along. That's all, you know, a submission doesn't have to be anything fancy and it's really important to get the input.

MS ABRAMSON: (Indistinct) comments.

PROF KING: And comments, yes. We actually have a comment site on our web page. To find our web page is very easy; open your favourite search engine, which I usually say, 'Google' - but open your favourite search engine and just if you put in Productivity Commission - Mental Health, first page that comes up, certainly in Google, is the one you need. That's easier than trying to remember an address.

Participants are not required to take an oath but are required under the Productivity Commission Act to be truthful in their remarks. Participants are welcome to comment on issues raised in other submissions. Transcript will be made available to participants and will be available from the Commission's website within a week of this hearing. Submissions are also available on the website.

Any media reps? No? Okay, well, I can skip that bit. To comply with requirements of Commonwealth Occupational Health and Safety Regulation, you are advised that in the unlikely event of an emergency requiring the evacuation of this building - Henry to advise on the day - - -

MR WILLIAMS: Look, I'll get back to you on that.

PROF KING: Well, hopefully we won't have an emergency before morning tea. I suspect head down the stairs, and I'd be amazed if the place we're meant to congregate isn't the park across the road - Sturt Park I think it is.

Okay, so they're the introductory comments. Well, what we'll do is we'll run through questions in a minute and really get your comments, your ideas and we'll have this as a fairly informal discussion. We've got until about 12.00. We can run overtime until 1.00 if, you know, we've got really good discussion if people want to make comments, particularly for a consumer or carer and you sort of say, 'Look, I'd like to make a comment, but not, you know, in camera for example,' that is possible right at the end. But we do have to finish by 1 o'clock precisely because we've actually got to head off to another meeting.

MS ABRAMSON: Not everyone has to stay the whole time.

PROF KING: Yes, and people can come in and out as you please, yes. Let's start off, however, by doing a quick run around the table. For those at the table, if you can just say your name, where you're from and then, we'll kick off for discussion.

MS HAYMAN: My name's Jan. I guess I'm representing Lifeline Connects today. I'm a volunteer and, yes, my boss recommended I come here.

PROF KING: Excellent.

MS SMITH: Vanessa Smith. I'm the manager of the Broken Hill Community Mental Health, Drug and Alcohol service.

PROF KING: Yes.

MR WHITE: Les White, Lifeline (indistinct).

MS SANDERSON: Joanie Sanderson, counsellor in private practice.

MS HINTON: Maxine Hinton and I'm with Lifeline as a counsellor.

MR GOUGH: Peter Gough. I'm part of the Maari Ma Aboriginal Health Corporation, their social and emotional wellbeing.

MS McMANUS: Christy McManus. I'm the deputy director for Mental Health, Drug and Alcohol, Far West.

MS BEESTON: Glenda Beeston. I'm a teacher and I actually work in the area of - well, student welfare teacher, but now known as Teacher Wellbeing Programs and I have my position because I am against school counsellor positions here in Broken Hill and basically there aren't enough school counsellors. So counselling is mostly what I do.

PROF KING: Okay, first thing that I'd like to touch on and I think Henry - sorry, Henry and Ros - okay, Ros, why don't you introduce yourself.

MS BELL: Rosalyn Bell. I'm the Assistant Productivity Commissioner which basically means that I've got the team of people that produce the draft report and organise everything.

PROF KING: She's the boss in other words.

MR WILLIAMS: I'm Henry Williams. I'm also the Productivity Commission and Ros is my boss.

PROF KING: Ros is my boss as well. Okay, what I'd like to start off on first is you mentioned counselling in school, but I'd prefer to start off more generally, initially. One of the things that we're aware of is once you get out of the cities, and quite frankly, once you get out of, you know, Melbourne, Sydney, Brisbane and Adelaide, services can be thin on the ground.

Now, one of you in my discussions just over a coffee sort of said, 'Wow, actually we've got lots of service providers here, but they may not be as well linked as we'd like.' So I'd really like your reflections on what's the availability of services like here. What's missing? Is there enough interconnection and linkage between services? Is there the coordination there that we need? Then, we'll lead off from there. So I'm open; my only thing is, and it's going to make the transcript I suspect a lot easier if, again, for the transcript you can say, 'Glenda,' and then

launch into it rather than - I'll try and remind you but, otherwise, the transcript guys have got to try and remember everybody's name. All right.

PROF KING: So who'd like to head off?

MS BEESTON: Glenda.

PROF KING: Glenda? Okay.

MS BEESTON: All right; Glenda. Because I work in a primary school of about 250 students. It's one of the large primary schools in Broken Hill, but it also has a number of students who deal with a lot of issues, it has a lot of support classes. I can have anywhere between 20 to almost 30 students that I see who are referred to me through the learning support staff.

PROF KING: Yes.

MS BEESTON: So some of those students actually access other places like Maari Ma, CAHMS are seeing other services outside of what the school can provide and I've always found that generally people are able to contact me, sign a release of indignation document and we can talk about the child; what I'm doing for them, what they're doing for them. Yes, and I've also visited - I mean not very often because I'm not a skilled counsellor, but I'm kind of acting in that position - even have been down to Maari Ma to have meetings for certain cases. But it doesn't happen a lot, but it does happen. So that's my experience of it.

PROF KING: Okay, with the students that you see at school how much of the interaction - well, are you able to interact more broadly with the family or is that because you're in a school position.

MS BEESTON: No, I've worked in both high school and primary.

PROF KING: Yes.

MS BEESTON: In high school, students can self-refer to the school counsellor or to counselling basically.

PROF KING: Yes.

MS BEESTON: In a primary school you have to have parent permission. They have to sign a document to say that their child can, you know, see somebody and, you know, basically come out of the class and miss some education and that lasts for 12 months.

PROF KING: Yes.

MS BEESTON: And I speak to parents if there's a particular need. If I'm not just working on something, like, say anxiety or anger issues because a lot of the children that I deal with end up having behavioural issues in the class; not all, but some.

PROF KING: Yes.

MS BEESTON: But I can also speak to parents about what they're doing outside of the school setting and, yes, so I speak to parents as well.

PROF KING: Sorry, I'll keep on the education side and then we'll bring it more broadly in a second, so, sorry, Glenda.

MS BEESTON: No, that's fine.

PROF KING: How are the children - so you said learning and support sort of says - you know, it'd be a good idea if you see - - -

MS BEESTON: Well, we have meetings once a week. I mean schools are very well set up for actually meeting once a week, finding out what's going on across the school.

PROF KING: Yes.

MS BEESTON: So children are referred through that situation and I talk to the teachers as well, so, sorry, what was your - is that the answer?

PROF KING: So really how the kids - one of the issues in dealing with is often the in-classroom teachers know that there's something not quite right.

MS BEESTON: Yes, they do.

PROF KING: But in many situations, they don't know who to turn to. It might be different at your primary school but really, you know, they're not sure because they haven't had training. We don't want to put more burden on teachers quite frankly because they're pretty busy at the moment.

So we were thinking there needs to be a resource that comes into the classroom, sort of somebody with some training, who can then sort of say, 'Yes, there's something going on here which is more than' - - -

MS BEESTON: Yes.

PROF KING: You know, take an example of a student who's been performing and suddenly performance goes down, attention in class goes down.

MS BEESTON: Yes.

PROF KING: So, yes, there's something here. Let's provide a gateway so this student can now, and their family, can get the relevant help that they need. So how does that look?

MS BEESTON: I think that does happen very well in schools actually because teachers will notice something.

PROF KING: Yes.

MS BEESTON: They'll talk to other staff; they will then refer that - they'll talk to people about learning and (indistinct) teachers. People can come in and do observations if they need to. You've also got your - it's generally your school counsellor. So generally those cases will be talked about pretty thoroughly and that's how it works.

PROF KING: Yes.

MS BEESTON: In terms of teachers' knowledge of what the problem is with the child and whether there's just something different, I think there is a fair bit of training out there now, and I do think though that it'd be great if there was far more sort of social and emotional - like, I guess lessons placed in the curriculum. If that was something in the curriculum, I think that would be really useful for teachers because I think kids need to learn all that sort of stuff.

PROF KING: Yes, okay.

MS BEESTON: But I think in terms of referring students who seem to be having some sort of problem, I think the schools are pretty good at sorting that out and then, referring them on through school (indistinct).

PROF KING: Referring them out through the process, yes.

MS BEESTON: Referring them out to other institutions or (indistinct).

PROF KING: I'll come back to the social and emotional wellbeing and bring the rest of you in as well, but just on the referral out to services.

MS BEESTON: Yes.

PROF KING: Does it actually work pretty well around Broken Hill? Are there enough services? Is it, you know, a case, you know, particularly child and adolescent that you're saying, 'Oh, well,' you know, You can get a service but there's a six week wait,' or - - -

MS BEESTON: Well, we've got lots of great services here.

PROF KING: Okay.

MS BEESTON: But I think just probably volume is a problem.

PROF KING: Yes.

MS BEESTON: I may be wrong here, but I think that places like Cairns have to deal first with, you know, very, very young children. Certainly they will see other children as well. Maari Ma's there for people. I think, you know, again, it's just finding the personnel, finding the people and having enough, you know, people available to actually see the student for as long as they need to see people, like, headspace.

PROF KING: Is there a bit of a wait as well - we've had headspace.

MS BEESTON: Yes, I think it can be huge wait in places as far as I know.

PROF KING: Okay.

MS BEESTON: It's fantastic that we now have headspace in Broken Hill. But to access that you have to be 12 and up - - -

PROF KING: Yes.

MS BEESTON: Between 12 and 25.

MS HAYMAN: And can I just interject?

MS BEESTON: Yes.

MS HAYMAN: They only have one counsellor at the moment.

PROF KING: That was Jan, by the way; just for the transcript.

MS HAYMAN: Yes, my name's Jan.

PROF KING: Yes, I know.

MS HAYMAN: Yes, they only have one counsellor.

PROF KING: Have one counsellor at the moment.

MS HAYMAN: So she's really, really busy and quite often she's sort of - it's very hard to get appointments with her.

PROF KING: Yes.

MS HAYMAN: Yes, we don't have enough counselling services.

MS CALLEGHER: I'd like to speak.

PROF KING: Yes, so, sorry, if you can state your name.

MS CALLEGHER: I'm Jodie.

PROF KING: Jodie, g'day.

MS CALLEGHER: I'm basically work for the family counsel support service at CatholicCare.

PROF KING: Yes.

MS CALLEGHER: Our engagement is with kids (indistinct) to 18 and we do get quite a lot of referrals with schools.

PROF KING: Yes.

MS CALLEGHER: Our fluctuation referrals I gathered is in regards to our capacity. We have two part-time workers; one full-time worker and we probably get around about anywhere from five referrals a week coming in. We don't have a wait list. We try to engage with those kids straight away. So we're an early intervention program, so I think that works really, really well with schools, like - sorry, Glenda is it?

MS BEESTON: Yes, Glenda.

MS CALLEGHER: Yes, Glenda, I apologise. Like Glenda said, we probably don't consistently get to all the schools in town, but we do go into most schools. We have one worker that goes out to - on a public school with - generally float around to most schools in town, whatever the highest of the needs of the schools at the time.

PROF KING: Okay, so not just the Catholic schools you go along to.

MS CALLEGHER: No, no.

PROF KING: Okay.

MS CALLEGHER: They're all public, we go to all of the - actually Catholic schools are the least of our school that we go to.

PROF KING: Right.

MS CALLEGHER: And that's basically because they're teaching - they have their own linked in counsellors and social workers and so they link in through Skype and they get a lot of their referrals and stuff, get their kids sorted out with online stuff.

PROF KING: Okay.

MS McMANUS: Could I just make some comments?

PROF KING: Please; so again, name first - sorry Christy

MS McMANUS: Yes, sorry; Christy.

MS BEESTON: I'm mentioning all these other (indistinct) .

MS McMANUS: Yes, so, thank you, Glenda because I appreciate that. So I work for the Far West Area Health, so I speak on behalf of CAMHS. So, yes, they do take higher acuity and higher risk clients and more complex clients trauma history. So age is not such an issue, it's about the presentation.

I think, and it's really good to hear about your service, because that's probably not something that I was not aware of - I feel, like, there's that gap between schools and CAMHS referrals because CAMHS can't pick up - even though they're fully staffed it's not a matter of - all their positions are filled - it's just a matter of not being able to take the lower acuity referrals.

MS BEESTON: Yes, that's true.

MS McMANUS: And the other comment was, yes, school counsellors are able to kind of identify and screen and know when someone needs to be referred. But I'm aware that not all the schools have school counsellors and sometimes these positions are vacant and that becomes a gap that health then sometimes are asked to come and fill or we get referrals that aren't as appropriate.

We do have two positions that are School-Link Coordinators and they're a link between our schools and health. One of them is vacant at the moment, but in the town of Broken Hill with the amount of schools that we have, the job is just spread to thinly I think and it's sort of - they try to focus on one school but be available to others, but I just don't think that the - it's hard for those positions to work effectively across all of the schools.

PROF KING: Can I then come back to the service navigation and interlinking because I'm going to pick you up on a comment you just said that, 'Well, I didn't know about that service.'

MS McMANUS: Yes.

MS CALLEGHER: CAMHS knows about that service because they refer to us regularly.

MS McMANUS: Right.

PROF KING: Okay.

MS CALLEGHER: So they'll look at a child and they go, 'Okay, they're not high needs,' and we'll send them straight over to them.

MS McMANUS: Yes.

MS CALLEGHER: So we do get referrals from them on a regular basis.

PROF KING: Okay, so coming back, though, Glenda, to the school, is it - - -

MS BEESTON: Yes.

PROF KING: I mean how do you decide where to refer to? Because you wouldn't know if CAHMS is full or if CatholicCare is full.

MS BEESTON: I wouldn't in my position.

PROF KING: Okay.

MS BEESTON: The school counsellor would decide that, yes.

PROF KING: Okay, and do you know would that be done I mean despite local knowledge or to get some (indistinct) - - -

MS BEESTON: Ideally with the schooling coordinator, yes.

MS McMANUS: Yes, that would ideally be the connection there.

PROF KING: Yes, so that's a position that currently exists or that's one - - -

MS McMANUS: There's two that currently exist.

PROF KING: Yes.

MS BEESTON: Yes.

MS McMANUS: And one of them is filled and one is vacant.

PROF KING: Okay, yes.

MS McMANUS: So one focuses on the high schools and the one that's currently vacant, focuses on the primary schools.

PROF KING: Okay, and that's the coordination link there?

MS McMANUS: Yes.

PROF KING: Okay, coming to the social and emotional wellbeing programs, because you mentioned, 'It'd be great if we could have more social and emotional wellbeing programs in schools' - - -

MS McMANUS: Yes.

PROF KING: Do you want to expand on that in the sense that - - -

MS BEESTON: All right.

PROF KING: What do we need more in our schools to help our young people?

MS BEESTON: Well, I think it'd be great if there was a wellbeing subject where kids learn about, you know, the signs of the world, the advantages of sleep, good diet, values.

PROF KING: Yes.

MS BEESTON: And actually also learn about things like to be able to I guess label things like depression, anxiety. Learn ways to self-regulate, just that whole area of wellbeing which

is, you know, relaxation, mindfulness. I just think that that would be great if that was embedded somewhere in the curriculum.

PROF KING: Okay.

MS BEESTON: So that students have a language to understand what's going on in their wider life and, you know, in families, amongst their peers. I think, you know, we hear a lot about mental health and we see advertisements on the television that sometimes that's presented I think as something outside of what's a normal life.

PROF KING: Yes.

MS BEESTON: Whereas I think it's very much part of the lives - like, school children, high school children for instance who might - if you look at any of the art works in Year 12, a lot of that's based on, you'll see, just them thinking about their issues, their problems, their anxieties, it's suicides through friends. I mean I think you need to give them some sort of forum in the curriculum for them to be able to talk about those things; learn about those things and possibly, in the future, then be able to prevent some of those things for themselves or if those problems do come up for them, feel confident that they can go and get help for that.

PROF KING: Yes. Well, there is money for - I think all schools receive money for social and emotional wellbeing programs and they seem to differ significantly between schools. Any thoughts on that? Yes, I'll give the worst example we came across where apparently there was one school who, because they were meant to report a number of hours for social and emotional wellbeing programs, they reported recess.

MS BEESTON: (Indistinct).

PROF KING: So that's an extreme.

MS BEESTON: Yes.

PROF KING: And I still haven't been able to confirm whether it's a war story, but it's a great story. So thoughts on that? Is it more funding that's needed? We get told the curriculum's too full. We can't fit it in.

MS BEESTON: That's true.

PROF KING: Is it the relevant teachers that are needed. What's missing? Why can't we do that?

MS CALLEGHER: Yes, I think that, like, in the Broken Hill area they do try to do that, you know (indistinct) interest. We have all of the organisations meet together, we have YSSI meetings with (indistinct) meetings which we all get together and we do stuff for the high schools. So we have programs that go into the schools to help support the teachers to have those outcomes around wellbeing, around anger issues. So we've got lots of different programs that go into the schools from - Mission Australia runs some, CatholicCare runs some, CAHMS I think are looking at going into some.

So, you know, we have identified that pretty quickly. I've been in the (indistinct) health support service for 10 years and one of the things that I have been doing on a regular basis - and obviously I can't get to all the schools - is a program around resilience, changing the way we think, how do we be more positive, friendship groups. The program itself is called Friends for Life which doesn't give it the right name because the kids actually think that it's all about being a friend to people, but it's not about that. It's about resilience and being a friend to yourself and having an understanding of your emotions, and it's a curriculum-based program and it can be run in a school base. So it can be run from as young as four, right up to age 12 and then goes into adult resilience.

So I've been running that one pretty much in the town for the last 10 years on and off. Obviously I can't run it to the whole schools, but I have touched based in lots of schools and I find that the schools are identifying that that is a need; it is definitely needed but it's about the capacity of teachers being able to run stuff in their class and from stuff from the community and everything like that.

This particular program, they have changed it a lot over the years, and it became online so which becomes quite hard. We've modified it a little bit, we did, you know, it's quite to do online when you're out in a rural community, especially places like Wilcannia and Menindee and things like that.

So it's just finding that, like, program for the schools that fits that school's needs. So each school and town is different.

PROF KING: Yes.

MS CALLEGHER: Like, one particular school might need stuff on peer relationship and so that's what they'll need from us and we go in and run little snippets of programs. We run self-esteem programs, wellbeing programs, anger programs, I think we've got about - we also do some in the preschools. So we do another little program called Little Highway Heroes and that's all about emotions. But obviously play-based; that sort of stuff.

PROF KING: Yes.

MS CALLEGHER: And I think health has been running that a little bit as well with their nurses, so the nurses that go into the schools.

PROF KING: Can I pick up on one point. So you immediately started talking about more than one program with the different offerings.

MS CALLEGHER: Yes.

PROF KING: One of the things we've heard talking to particularly school principals, so the reaction is, 'Yes, I'd like to do more, but there's all these programs and I don't know which ones will work and which ones don't.'

MS CALLEGHER: Yes.

PROF KING: And quite frankly, we've talked to some providers of programs who I'm not sure that there's any evidence that their programs have any affect whatsoever, but again, the school principals don't know; I mean they've claimed in this area. So often they'll choose a program by going and talking to other principals or other teachers or people who have got some experience. Would it be better to have - do we need to help the principals themselves to work out, well, what are the needs in the school and what programs we need in this school.

MS McMANUS: I think so.

MS CALLEGHER: Yes.,

MS McMANUS: And I think you're original question was, 'What do we need?' I think I feel like we need more of a structure. So for our School-Link Coordinators they would be happy to run programs, but I would like to see that one of your roles is to run - there's these options of these five programs that we're going to train you in, and across the state, all of our School-Link Coordinators are trained in these five evidence-based programs and we deliver these based on depending on what schools need and so that there's a consistency across the state in evidence based programs, so we're not sending people off to another training and we come back, and we've got 10 people in the town trained in 10 different trainings and they can't deliver them together because there's so much variety.

PROF KING: Yes.

MS McMANUS: I just think if we had a bank of evidence-based programs that we agreed upon, we could be so much more effective in our delivery.

MR GOUGH: Just to speak to that, Mr Commissioner, the - - -

PROF KING: Call me Stephen, by the way, not - - -

MR GOUGH: Sorry, Stephen. Maari Ma runs school-based programs specifically for Indigenous kids.

PROF KING: Yes.

MR GOUGH: At last count, there was close to 300 programs operating in Wilcannia - well, over the last few years there's 700 people.

PROF KING: Sorry, 300 different programs?

MR GOUGH: Sorry, so there is a little bit of overlay (indistinct) want their principal.

MS McMANUS: Yes.

MR GOUGH: That's not just school-based.

PROF KING: Sorry, that's 300 school-based programs or 300 general programs?

MR GOUGH: No, 300 overall programs.

PROF KING: Okay, but still - - -

MR GOUGH: 300 (indistinct) so there is a huge amount of confusion and sidelining that goes on. There has to be a way to integrate all programs, but there is not.

MS McMANUS: Yes.

MR GOUGH: Everybody has their own - I won't say agendas, but they've got their own values and their own mission statements, which is wonderful and admirable, but it's definitely overloaded out here.

PROF KING: Okay, by the way, just for the transcript; that was Peter.

MR GOUGH: Sorry; Peter.

PROF KING: Yes, no, I completely forgot to so my apologies.

MR WHITE: Les.

PROF KING: Yes.

MR WHITE: I have a question here for Jodie and Glenda, but they're (indistinct) was why education? How many of you know of Life Education and some of them (indistinct) have heard of them and had a lot (indistinct) in schools and whether there's still connections at all with the schools with Life Education. Do you remember the program?

MS BEESTON: I remember Harold well.

MR WHITE: Okay, so you we've got three there, yes.

MS BEESTON: Yes, I don't know whether it's still running. Sorry, Les.

MR WHITE: I was involved in Life Education when it came to Broken Hill right from the first meeting that was called.

PROF KING: Yes.

MR WHITE: I got the (indistinct) Life Education then at that meeting and supported it for the full 10 years that it was involved in Broken Hill and I to me, at that time, that was the program that was set up to educate kids from when they first started school, right through to high school and then, I think later on it was actually implemented into some of the high schools. But I'm of the very firm belief that if you grab children earlier enough and start to educate them very, very early in their lives, that you can make a difference in their lives and over the years I've met people and asked that question of how many people, you know, when Harold comes

up or Life Education comes up, how many of you saw that program, and are you familiar with the program at all?

PROF KING: The details, no; but I've heard of it.

MR WHITE: Yes, right, you've heard of it?

PROF KING: Yes.

MR WHITE: It was basically taking kids from healthy eating, healthy care of yourself, not smoking and all that sort of thing.

PROF KING: Yes.

MR WHITE: We took the van at one stage up to Menindee to the old mission site up there and opened it up and set it up for the full day and the parents were invited to go through with the kids that were there and, of course, the kids wanted to come too, 'Look, mum, look, dad, look what we saw; this is what we see,' and of course, mum and dad went through at 100 miles an hour. They didn't want to see it because basically what it was saying was if you moderate and cut the smoking out, moderate the drinking and all that sort of stuff, to educate the kids early enough.

I'm not too sure how many lives hopefully that program would've saved, but they didn't seek the program out here because, as I said, I used to do all the maintenance on the vehicle. It was a (indistinct) that was two thirds the length of this room and had all the gear set up and they used to close the room off, and in the ceiling, there were all diamond-shaped - like, star-shaped holes and when you turned the lights on they were just lights, you know, from the stars.

PROF KING: Yes.

MR WHITE: And then they had this program teaching the kids about smoking and that sort of thing. I'm not too sure, when I look around and see the number of people that are smoking, how successful it was but it was basically grabbing the kids early in life and teaching them how to care for themselves, like I said before, healthy eating but - - -

MS McMANUS: Christy; I think it also had - the thing that I liked about it was the protective behaviours, children being able to talk about keeping their body safe and things like that. So I agree; I think that's a good example of a really positive program and that's one of many and I guess that's about how do we all navigate many of these amazing programs.

MR WHITE: Well, I'm actually interested now, is there anything that took the place of Life Education in the schools now?

MS McMANUS: Not so holistically that I can think of.

MR WHITE: Because that was very broad, but it was one of those things that we had the educators out here and they were very good at their job. My concern was we had to make sure that we supported the educators as best we could because we were taking (indistinct words) it

was always the young lady and she would come out with the van, she would be shipped out in (indistinct) usually - not all of them but some. Then we would send them out into the bush to (indistinct words) and all those places and take this vehicle on all the rough roads and all that sort of thing. It was well supported by Gary Rathburn and quite a few other people in the district, who as you can imagine it's a (indistinct) it's a full semi-trailer.

So (indistinct) shifted, and it was shifted by Bradfords and quite a few – like I said, quite a few of the other people. They did this stuff free of charge, and I did my whole ten years work on it free of charge until the last year that it was here. They said to me, 'We'd like you to put in a bill', I said, 'Why?' They said, 'When we moved the van around to all the other places we get accounts for \$1000 for this and \$200 for that and \$700 for that, when it comes to Broken Hill, there's no record of what's spent on it. But I said, 'I do give you a record of what I've done', they said but there's no cost involved, 'So give us a cost for \$30 an hour or whatever the going rate is then give us a bill for what you want', right. So I put it in as a dollar an hour and then donated the money back to - - -

PROF KING: Can I ask – because one of the things that you've raised and has been raised by others, is are different schools and different communities, and I'll broaden it out a bit to the whole community, have different needs, different requirements. To what degree do we need different approaches, not just depending on the school community but also – well, does what works in town, would it work in Wilcannia or does it need to run from a different perspective. How much does, you know, whether it's a school program or whether it's a broader provision of social or emotional wellbeing at the community level, how much does that need to depend on the community that they're serving?

MS McMANUS: Christy. I would imagine that our early intervention programs could be similar across areas. But Wilcannia's got a high indigenous population.

PROF KING: Yes.

MS McMANUS: And I think the programs that we run there need to be culturally specific and appropriate to that population.

PROF KING: Yes. Other thoughts, yes?

MR WHITE: Les (indistinct). Talking about Wilcannia, in particular, when they contacted me and said we're taking the van away and no longer be coming out your way, I said, 'Why', they said, 'The cost.' I said, 'So what's the problem?' They said, 'We can service five or six kids on the coast for the price of servicing one in Wilcannia and Tibooburra but particularly Wilcannia.

PROF KING: Yes.

MR WHITE: And I said, 'Well wait a minute, you're telling me that the life of the kid in Wilcannia is not as valuable as the life of the kid that's on the coast?' And they said, 'We're not saying that.' I said, 'Wait a minute, you are saying this – exactly this, the life of the kids in Wilcannia are not as valuable as the one's on the coast. We can service five over there for one

out here.' I said, 'I can't see – I can't see how that can be so, you know, the life of the kid in Wilcannia is just as valuable as any other kids on the coast.'

PROF KING: Yes.

MR WHITE: But I was very angry about that. They said, 'What we're going to do is, is replace the program with taking an educator and putting them in a station wagon, load all the gear on that' and they did that. And they did that for a while, they were coming out until a few years back. But reading about the program would be in the back of her station wagon, whatever she had she would (indistinct words). But the great thing is you would be able to me, Christy, your feeling of when you were in the van and how – what an impact it would've had on your life.

MS McMANUS: Yes, look, I think it was a great program. So I – yeah.

MR WHITE: But I know that things run their course.

MS McMANUS: Well, I guess it's – is that the program we're going to focus on but whatever it is that I guess we focus on, it would be nice if it was consistent and it would be nice if we – and there needs to be sustainable, I guess. And that's – and I don't know why that stopped but for whatever reason, whatever we look at needs to be sustainable - - -

MR WHITE: They told us it was money because I visited the – the base of Life Education and actually did a job while I was over there, had a breakdown on part of the (indistinct words) audio visual stuff and I fixed that because I've actually worked on it on the van.

PROF KING: Can I ask, so we've heard from indigenous communities by indigenous Australians, that really to get culturally appropriate programs and again they could be school book, they could be community, really that means that there's got to be community control or it doesn't always have to be an indigenous controlled organisation but that's the preference, if the relevant services can go through the indigenous community controlled organisations or indigenous controlled organisations, then they're likely to be much more effective. So I'd like comments on that.

MR GOUGH: It's Peter, we run a number of programs, mainly for adolescents throughout high schools here and Wilcannia.

PROF KING: Yes.

MR GOUGH: And have – and my colleague Karen, who runs those has had outstanding results on the culturally based programs such as – the one that comes to mind is Seasons for Growth.

PROF KING: Yes.

MR GOUGH: Managing the adolescents and the engagement, probably A for her personality and she's not indigenous but does a wonderful job. As well as the relevance and the cultural relevance of the content, and sees kids even in Wilcannia turning up time and time again to

participate, where a lot of the times those programs participation is minimal at best. So there are programs out there and that's just one that I mention, that are, if they are cultural appropriate and (indistinct words) which is identified by the community themselves, whether that be the teaching community or the elders within that community, such as, (indistinct) relationships and teenage pregnancies, people are interested.

PROF KING: Yes.

MR GOUGH: It's not just, 'Here's a program, and we run it'.

PROF KING: Yes.

MR GOUGH: As is evidenced by about 300 (indistinct words). I think the other issue is the efficacy of those is really measured, I think. So I hear my colleague over there talk about the program, sounds a wonderful program, but in this day and age of financial, I suppose, management we have to measure the effectiveness and I find that there's a lot of research that goes into these programs that they are obviously (indistinct) otherwise there wouldn't be any air time but the – but the actual results is very subjective and self-serving for some people who may not have done so well. So I think there has to be a focus on the academia side to measure the result and it also has to be culturally appropriate. Not just indigenous culture but they listen to country and western music out here. It's not the inner-city where a lot of the policy makers tend to reside. They are a different culture by being removed and (indistinct) isolated.

PROF KING: It's also – I mean, just on the cultural part, so for example, I kept picking on Coburg in Melbourne just because - - -

MR GOUGH: It's easy.

PROF KING: - - - that's an area. My wife's a clinical psychologist, by the way, (indistinct words) and so she works with a lot of the Islamic women – not that my wife is Islamic but she's Indian and they're simply – you know, she grew up in a country which has, whatever it is, 350 million Islamic people so she actually understands the cultures and being brought up there for some 20 something years. So in Coburg you also need culturally sensitive and relevant services. It's just the culture is different and so I think that's one of the challenges of making sure that, you know, because even the concepts of mental health differ between communities and differ depending on cultures. Can I – sorry, I've now lost my train of thought on that. I'll do online – no, I'll do suicide next. Des, if you can introduce yourself, by the way?

MR JONES: Yes. My name's Des Jones, I'm (indistinct words) Chairperson of (Indistinct) Aboriginal Housing and Chairperson of (indistinct words). But I think I've been (indistinct words) conversations going on but I think the realities out here in the remote section around mental health is some communities are blessed with services but there's been no audit of who does what, who's eligible to access those services within aboriginal and non-aboriginal, you know, so we need to do some auditing around who's actually providing services, what are they and I think, you know, there's an emerging issue around, you know, social media and all this sort of stuff that's a different type of – not (indistinct words) different emotional well-being, sort of, issue that's emerging in our community and dividing some of our families, dividing some of our community. So we need to understand what's actually going on now with some

of the stuff that's happened previously around the issues that affect mental. And I'm no expert in (indistinct words) family, you know.

PROF KING: Yes.

MR JONES: But I think with the experiences we've seen, like, there are some resources (indistinct) resources out there that are available for non-clinical programs, mental health and social, and emotional well-being and there's also the clinical approach. So you've got to marry them up somehow and make sure that they are, there's some sort of pathway of flow for people, so that if I access a service, it links me into other services, you know, I just don't get (indistinct) for the sake of the funding, do you know what I mean, and I've seen it happen, so. So we need to be mindful of all these things that happen when people put submissions in access resources. And, you know, I've seen a lot of the 70/30 sort of mix where 70 per cent admin, 30 per cent service.

PROF KING: Yes.

MR JONES: So when you look at how do we make that work (indistinct words) because if it's about, you know, building your structures, it's not about the clients? So we really focus on what the client needs are and the community, so (indistinct words) communities around their priorities, I suppose, around what they see as their priorities as community action plans, we call them. So they should also be respected in the planning process and have a look at and be included in that whole discussion around what are the best things that happened for those communities because, you know, Broken Hill (indistinct words) live the next street is different, don't worry about the next town, do you know what I mean?

PROF KING: Yes.

MR JONES: So we've got to be aware of (indistinct words). So we're all not doing this sort of, you know, on the same wave length, I suppose. Stephen, the big one for us and we've raised it for years around mental health is, over the Easter period you've got four days of nothing, do you know what I mean? But (indistinct words) something like that. So that's got to be fixed up somehow or any public holidays where people that are – whether it's a family or whether it's the client, require a service.

MS HAYMAN: Jan. I agree. Over Christmas.

MR JONES: (Indistinct words).

MS HAYMAN: Yes, a week or two, you can't access any services at all.

MR JONES: Mental health doesn't take public holidays, does it?

MS HAYMAN: Yes, it doesn't take a holiday, exactly right.

MR JONES: So we need to be mindful of that so those people do get access to – including their family members without being the first port of call in severe cases of police, you know.

(Indistinct words) that rock up to the door and sometimes that can be too regular which means it makes matters worse around the client anyway.

PROF KING: Yes.

MR JONES: That the police are called to (indistinct words) as a first responder. So somehow we've got to change that.

MS McMANUS: Yes. Christie from (indistinct). So speaking from (indistinct) I don't know what other services run on public holidays but from Far West Mental Health Drug and Alcohol perspective, we don't have our clinicians on the ground on public holidays. But we do run an after-hours emergency service. So what that looks like is we have links with Orange and it's a teleconference – it's a tele-psychiatry and counselling service, so people would (indistinct words) come to our emergency department with acute presentations. And they would be - - -

PROF KING: As in the hospital's emergency department, yes. Okay, yes.

MS McMANUS: Yes, the hospital's emergency department.

PROF KING: Okay, yes.

MS McMANUS: And that would result in a tele link with Orange for that assessment and we also have an on call psychiatrist that runs 24/7, so that service would contact our on the ground on-call psychiatrist who if required is available to come in. So if there was an admission to our in-patient unit or anything like that then (indistinct) continues to run. So probably what, over public holidays does stop is the response to lower acuity presentations and I can't speak on behalf of any other services if anyone else continues to operate on public holidays. But from our perspective that's how we run the service.

MS SMITH: Vanessa. Also for the outlying areas the same procedure where people could go the local health service and access that video conference and psychiatrist service.

PROF KING: Okay - - -

MR JONES: And (indistinct words) with mental health don't leave their seat, you know.

MS SMITH: That's right.

MR JONES: So we've got respond to this in a different way.

PROF KING: Yes.

MR JONES: You know, it may be (indistinct) services that want to work over the public holidays. We don't know yet but if (indistinct words), you know, so (indistinct words) we can do that, you know.

PROF KING: So how do you make that doorway though, particularly, you know, public holidays or out of hours services, how do we make it affective because as you said it's not just

an issue in the bush, it's also an issue in the cities where someone may be just not feeling well, they're deteriorating, there aren't the services there because they're not ready, you know, they can't rock up to the hospital. The hospital would say, 'No, you're not sick enough to be here', until it really goes bad and then the police are called and they're taken along to ED and ED is not a great place with mental health issues. How do we – how do we – sometimes that gap - by the way it's referred to as 'the missing middle', but you know, if you can get – if you can be in community in town, you're well enough to deal with a counsellor or a psychologist, that's fine. Down at the other end, if you're bad enough the police take you to a hospital and you can get the services but there's nothing in between. So how do you think we can start to fix that sort of issue, because the last thing you want is somebody to deteriorate to the point where the police are called?

MR GOUGH: Peter. I think that all our services here bar the – bar West Health is sub-acute. So we are not emergency crisis situations.

PROF KING: Yes.

MR GOUGH: Although we do get crisis presentations regularly. So in many respects the reason why I'm sure my colleagues across the road don't open on public holiday is they haven't got enough funding to open through the week let alone public holidays for staffing. So with penalty rates, the cost of that, trying to protect their people who, you know, they're on the (indistinct) all the time with very little time off to give them some quality time to recuperate and regenerate, is paramount. However, there's no funding for wages for that.

PROF KING: Okay. If the funding was there, would the workforce be there?

MR GOUGH: Possibly, there would be some people who value their time off, some people who can manage their time in a different way, so - - -

PROF KING: Yes, I'm slightly a different direction. If you were going to run a 24 hour service you'd need more counsellors, you'd more psychologist, and you'd need more social workers.

MR GOUGH: I suppose it's like a lot of public sector organisations that stay open, such as even the police force.

PROF KING: Yes.

MR GOUGH: Some people want to work those days to make some money and they'll have other days off. You know, they might be more interested in school holidays than public holidays. So I think that's very doable but I don't necessarily think that going to the – to the organisation and handing out the money, saying 'Can we have some more income for wages just to cover stuff', I don't know if that's going to actually achieve any results.

PROF KING: Well it depends if they come up with the money, I guess.

MR GOUGH: Exactly. You know, everybody runs on a shoestring, I don't see anybody driving around in flash company cars.

PROF KING: Yes. No, no one of the benefits of the Productivity Commission is that if we've got the evidence to sort of say, 'Look if you spent an extra million dollars here, guess what guys, you'd be saving this many lives and you'd actually be saving public hospital admissions and the benefits are multiples of that', you can - - -

MR GOUGH: I'm completely focused on that funding model and not one to say just throw money at it but I think in that respect it's sort of - - -

PROF KING: Yes.

MR GOUGH: Yes.

MS McMANUS: Could I - - -

MR JONES: (Indistinct words) you do or you don't, you know.

PROF KING: Yes, that's right.

MR JONES: It's going to cost you so you might as well do it. I think – I think, like I said earlier a lot of it doesn't have to be clinical. So you can have community programs done on the weekend so these people can access that service if they're not feeling too well or if they feel (indistinct words) and access it. But it's preventing it – preventing it to get into a crisis point, you know what I mean?

PROF KING: Yes. Sorry - - -

MS SANDERSON: Joan. This is just going back to the school thing, I'm sorry. But I think that we need to learn something from first nation people and – about I think sometimes our programs right across the board have become fragmented because we're always trying to reinvent new things and I think we need to go back to basics. And instead of going out I think we need to come back to simplicity and, you know, a beautiful indigenous man I was talking to one day said to me, 'You white fellas have too many words', we have to – you know, we want to bring it back to simplicity.

And I think when we're looking at children's programs whether it's in Wilcannia, you know, having things around or Menindee but also in Broken Hill, I think we need to go back to basics and instead of trying to invent new things we need to bring it back to simplicity and start from the ground up and look at how can we make this simpler. So instead of having all these fragmented programs that are out there and nobody knows why I do this or why I do that, because we've already got that on the internet and there's all these choices and everybody's brain is going at a thousand miles. I think we need to bring it back to the simple things, you know, on the ground, what's needed and run it out right across Australia, all the programs but just tweak it with different communities.

PROF KING: Yes.

MS SANDERSON: But just have it so that it's easy accessibility to everybody.

PROF KING: Yes.

MS SANDERSON: And so, you know, you don't want to put more pressure on teachers, like, you have to, you know, you have to pick a program. Like, just have it so that it comes back to basics again. So anyway, that's - - -

PROF KING: No. In some ways that's a good summary of, sort of, where we've been heading which is to say, we want to make sure that there's evidence behind the programs. So at the national level, we've suggested to the National Mental Health Commission, 'Actually evaluate the program, and work out what works, where the evidence is.' And then at a local level basically says, 'Look here's a list of programs that works at a local level, choose which ones you think will best match the needs at the local level.' So that's sort of what we're (indistinct words) about how to do that simplicity which you've been saying.

MR WHITE: Les. Just a question for Des. Des, you still have indigenous liaison officers employed in the police, do you?

MR JONES: Yes. There's a community liaison officer there.

MR WHITE: Community liaison officer, I'm wondering how well they're trained?

MR JONES: Their roles are different, their liaising people, do you know what I mean?

MR WHITE: Yes.

MR JONES: They're not actual referral people and all that sort of stuff, it's about just - - -

MR WHITE: Because they really should be the first person on the scene when they're called to a domestic or something like that. That then they – they should be in first – they should be part of the – the first responder work, shouldn't they?

MR JONES: Yes, I (indistinct words) situation, I think it depends on what's going on.

MR WHITE: Yes, because that's when a lot of the – that's where a lot of the trouble would come from, I imagine, that (indistinct) more concerned, like I said before about the younger ones (indistinct words) called to a household where there's a teenager or even younger than a teenager causing strife. Whether there's somebody there that knows how to handle that situation and the – like, people saying that a number of programs that operate in Wilcannia, I'm just – I mean, I did hear at one stage there were 60 agencies in Wilcannia at one time. You know what I mean, and that I thought to myself at the time, how ridiculous is that?

PROF KING: Yes.

MR WHITE: You know, you surely don't need 60 different agencies trying to function in - - -

PROF KING: Yes. No, we did look at more broadly at services provided to indigenous communities about four years ago and the worse one we came across is that there were more service providers than there were people in the community. I can't remember which community it was, I think it was in the (indistinct words) somewhere. But yes, it was – it was interesting that - - -

MS SANDERSON: Could I just add – sorry, I was just thinking of - Joan. Like, from what I observed in the community, now people have to apply for funding for this and that, it then becomes about having to tick boxes so that you don't lose your funding. And the ticking boxes sometimes becomes more important than the people that you're actually servicing and I have seen that right across the board. That's where I'm really happy that I work for myself because I don't have to – because I just think, you know, workers are having to spend so much time in the office because they're – and they'd rather be out on the ground working with people but because of the funding bodies they have to answer to them and it becomes about the ticking the boxes, and they have to have completed all these things. But you know, what's happening to the people on the ground that the funding was actually given for?

PROF KING: (Indistinct words). Yes.

MS McMANUS: Yes. There's a couple of comments that have been made and Des said, 'Yes, we've got lots of services but we've got this heavy admin component, there's only a few people doing the job.' I feel like that's what I've – we find, there's – there's lots of services available but when you contact there's a wait list or they're full (indistinct) whatever, so that actually each service doesn't necessarily have the capacity to meet the needs even though there's a lot of services. So the other – I agree Joan about the ticking boxes and funding and I think we're seeing more of that.

Back to talking about after hour supports and the Aboriginal liaison, on one of the recommendations 16.1, was whether or not we put mental health professionals or clinicians with the police department.

PROF KING: Yes.

MS McMANUS: My thoughts on that was that maybe in Broken Hill, I don't feel like that could – would be a full time role. But I certainly think it would be absolutely helpful to have someone that – that was a focus of their role, for example. And that they were available to police to be called out to attend those scenes, and I thought maybe – sorry Broken Hill, Wilcannia and Menindee, the far west.

PROF KING: Yes.

MS McMANUS: I don't know if having someone sitting in the police station waiting for those would be a good use of their time.

PROF KING: Yes, is it a good use of resources, yes.

MS McMANUS: But I think it is a good position and maybe it could be spread across a couple of other – other services. And the next thing I was going to say, I can't remember, so I'll come back.

PROF KING: Could – sorry, yes.

MR JONES: There's a lot of energy in the back of end of services, you know - - -

PROF KING: Yes.

MR JONES: - - - got to happen before someone (indistinct words) service. So and – and we need to (indistinct) all that first in order (indistinct words) whose doing what because the data will tell you that's what their focused on, those areas, all right?

PROF KING: Yes.

MR JONES: I'm talking about that (indistinct) stuff, you know, all the upfront non-clinical approaches where they don't go - - -

PROF KING: Yes.

MR JONES: - - - appear on the radar, you know, and - - -

MS McMANUS: Yes.

MR JONES: - - - match them up in (indistinct words) so if you can remember (indistinct words) you know, our community is not functioning, you know or functioning well (indistinct words). And all of a sudden (indistinct words) influences come in, you know, like the alcohol, drugs, the social media stuff, high unemployment, you've got all these things that compound on what happens in a community and it affects a lot of people too. And if you're struggling families are – are being torn apart by mental health or other things, all right, well where's the services to get them without being clinical, to – just to support them before they get to, you know, because the police shouldn't be picking up all the pieces. You know, they're an enforcement agency, they're not a social (indistinct words). If we're going to make sure what's on the ground now is actually working.

PROF KING: Yes.

MR JONES: And if it isn't working, do something about it.

MS BEESTON: Could I just jump in there, Des. I think – I just think needing people on the ground and needing people in a community who know the community members who know the youth in a personal way, I think youth workers, the employment of youth workers and those sorts of people would be really, really useful. Because they – it's not just about going to a service and getting help, I've got this (indistinct words). I think, you know, relationships are a huge factor, like even in education, if you've got a relationship with a child you're going to help all the family, yes, you're going to help them far more.

And I think, apart from a whole lot of sporadic little things happening or going (indistinct) and that (indistinct words) help, if you've got people on the ground who have a personal relationship and a youth worker - and often I think it has to be males, I hate to say that, but I think that would help enormously. Some of these communities could employ those people who live in the community, know the (indistinct) the kids, know the adults, know the families and can actually then be a soft entry point also for people that do need help that, as you say, some people they don't (indistinct words) sick, they don't know they need to present, and it gets to that point where they're already at crisis and - - -

MR JONES: And (indistinct words).

MS BEESTON: - - - before you pick them up. So I think you need youth workers (indistinct words).

MR JONES: Or family workers, people who work with families.

MS BEESTON: Family workers, yes.

PROF KING: Yes.

MR JONES: But it has to change (indistinct words). We can't continue down this path, you know.

PROF KING: Yes.

MR JONES: The more resources you throw at it, the bigger the problem seems to get, you know.

PROF KING: Yes.

MR JONES: I think it's about how we do it better.

PROF KING: Vanessa were you (indistinct)?

MS ANDERSON: You know, I was just sort of thinking back about the, sort of, availability of like a kids services for like public holidays and what not. But, you know, the idea that we have some sort of tiered approach available in the community. Currently we have a – Mission Australia run a program called Connections which is a social, an activity program that's run after hours and on weekends that support people with mental health issues, you know, people can come along and partake in that. So there are those types of services that available, I don't imagine they're available for public holidays and extended periods. So given that the feedback we're getting about those services that they're working really well and people are finding them useful, if they could have additional funding to be able to run, plus perhaps the step that's then missing is something that might be between a service like that and the emergency department or the police. So, you know, having other perhaps, you know, clinical people involved in a service like that. That would then - if the person did need to go to the ED they could support them to go to the ED - - -

PROF KING: Yes.

MS SANDERSON: - - - and make a sort of - a more effective (indistinct words)

PROF KING: So it's not handcuffs and the police taking you in, yes.

MS SANDERSON: Precisely. So they could sort of advocate and facilitate a more helpful experience, yes.

MR JONES: Make it (indistinct).

MS McMANUS: Christy. And one thing that I think of that's obviously happening is the zero suicides in care funding and one of the initiatives of that is the Safe Haven Café model that we are strongly supporting. So an alternative to an emergency department where a more early intervention approach that would be available after hours, on weekends, ideally public holidays, that would be run by peer or people with lived experience or peer workers, youth workers even. I love that idea. But with a trained clinician who is then able to identify if something needs to be escalated to the emergency department.

But that police and ambulance also would have an option or if they - you know, went to a scene or something and said: do you want to - do you want us to drop you down to the Safe Haven Café? You can have a coffee. You can have a chat. You know, ideally it'd be Aboriginal peer workers that's there as well. That would maybe prevent or be an interim step to a more acute mental health (indistinct).

MR JONES: And this follows on from that for me. Most people that are in that space don't care what worker it is, you know, Aboriginal or not. They just want some support. So the more - the more support or the relationships that person has got in a department - - -

PROF KING: Yes.

MR JONES: - - - that's the first one they'll respond to when it's (indistinct words). The (indistinct) are having a lot of divisions in our communities now. So, you know, not even on the same sort of wavelength or relationship. The right person will be - will be the right person because everyone gels with that person based on their skills, and you see that (indistinct) people go to people that they trust. People comfortable and are safe, you know.

UNIDENTIFIED SPEAKER: Yes.

MR WHITE: Les, from Lifeline. I'm - sorry.

PROF KING: No, no, Les, you go. I mean - - -

MR WHITE: I've been involved in Lifeline for over 30 years, and I spent 16 years on the telephone.

PROF KING: Yes.

MR WHITE: And to me that's the first port of call. That people have got to get to - quite a lot of people they get to the stage where they've got the rifle under their chin, which I had one guy. He had it there for 45 minutes.

PROF KING: Yes.

MR WHITE: And after 45 minutes took the bolt out and I said, "What was that noise?" and he said, "That was the bolt coming out. I'm not doing it today, but I'm not saying I'm not going to do it."

PROF KING: No, no - - -

MR WHITE: "I'm not doing it now" and that's what the thing is. We'll need to have somebody that's available now.

PROF KING: Yes.

MR WHITE: Not 9 o'clock tomorrow morning until 5 o'clock tomorrow afternoon.

PROF KING: Yes.

MR WHITE: It's now at 3 o'clock. I used to get a lot of my calls at 3 o'clock in the morning.

PROF KING: Yes.

MR WHITE: You know, 4 o'clock. The phone actually started - I can remember when I took over at about 10 o'clock, the phone would ring when I walked in, and you would be on the phone continually. So I got to the stage where I actually had to hang the phone up for a few minutes to give myself a break, to get that - - -

PROF KING: Yes.

MR WHITE: - - - that call out of my head, so to be ready for the next.

PROF KING: To focus on the next one, yes.

MR WHITE: But, you know, you - that's - I feel that Lifeline is - fills the bill there, but of course that needs funding. It - - -

PROF KING: Yes.

MR WHITE: - - - will need funding.

PROF KING: Can I - Peter, can I - I'll come back to you in a second but just before coming back to you, because we've sort of danced around technology a few times. So telephones obviously old style technology. I think having counsellors or clinicians available through Skype call type of thing, so it's through the internet and other - to what degree - but we also mentioned say having youth workers, people on the ground. To what degree can we use

technology, and again I'm thinking, you know, the police liaison person or somebody - yes, we don't necessarily want someone sitting in the police station 24 hours a day, but you do want somebody the police can say, look, we've got an incident, can we use technology to try and help overcome these sort of barriers to getting the services where we want them.

So any thoughts on that and then I'll come - Peter, okay, lead on.

MR GOUGH: It's an area I'm very passionate about. Sorry. Peter. I was a policeman for 21 years, an inspector working in remote and rural New South Wales. Worked in Bourke, Cobar, Griffiths, Moama and up the north coast. So very specific indigenous populations with different cultures. With my view on this now being in the psychology world, ACLOs aren't designed for mental health. So we've got to discredit that. ACLOs are from the community, and if they're involved in a mental health incident there will be a conflict of interest there. I work with people in this town who are conflicted with their family being involved, not wanting to disclose mental illness, let alone letting it all out there. So confidentiality - - -

PROF KING: Just ACLO, just make sure, Aboriginal Community - - -

MR GOUGH: Aboriginal Community Liaison Officers.

PROF KING: Yes, I thought I'd better get that on the transcript.

MR GOUGH: They're from the communities, they're not trained. The police have actually got a great mental health network. If there is an issue there are people that they can refer to on call all the time. The police are only called as a last resort. So it's obviously family first. They're very conscious of that. I'm not standing up for the police just my understanding of transition. If that doesn't work it's ambulance.

PROF KING: Yes.

MR GOUGH: If it becomes violent or not intentionally violent but through somebody not wanting to go, that's when the police are called, and that's purely for transport.

PROF KING: Yes.

MR GOUGH: So it's not for - if they have to restrain it's for the right reasons. It's not for any other reason.

PROF KING: Yes.

MR GOUGH: To get them to a safe environment where they can be treated by medical people, because it's a medical problem.

PROF KING: Yes.

MR GOUGH: It's not a law and order. So they're purely transport. So I don't think having people with the police to go to mental health incidents is of any value at all now, because it

will be ambulance officers there. There may well be a CAMHS team or a critical response team. In regards to - sorry, were we moving on to Telehealth?

PROF KING: Technology, yes.

MR GOUGH: I work at Wilcannia Hospital once a week and my mobile phone doesn't work in there. So good luck with that.

PROF KING: Yes. All right.

MR GOUGH: I've worked for Corrections in Victoria. I've worked on - in Telehealth. But these people were forced in, say somebody is in Mildura and I'm in Shepparton or somewhere like that.

PROF KING: Yes.

MR GOUGH: It's okay at best. There is no better counselling than face to face.

PROF KING: Yes.

MR GOUGH: To develop rapport, trust, the hand gestures, just the environment. It's very stark when it's in front of a TV screen.

PROF KING: Yes.

MR GOUGH: Now I haven't met Des yet but working for the same organisation and my cultural knowledge, which is expanding daily, is that I don't think it would work in indigenous communities. I don't know what your thoughts are Des, because they value communication.

PROF KING: Yes.

MR GOUGH: It's about relationship and rapport. There is a place, I think, once that rapport has been developed, I do it now where I have phone consultations with clients, but I've already formulated that - that rapport. So in relation to counselling I think yes. In regards to treatment I think no. Because proper CBT, proper DBT - sorry, therapies - - -

PROF KING: Yes.

MR GOUGH: Cognitive behavioral therapy, dialectical behavioral therapy, especially for trauma ridden communities like this, require some tools. It requires some white board, it requires handouts, it requires interaction and explanation, and I don't think Telehealth does that when we're talking treatment. It may well for counselling, and I've done some great counselling sessions over the phone. So we have to delineate between (indistinct). So if there's a person in trauma well you've got to be with them because their whole world has been corrupted and it's that personal interaction that must be established.

PROF KING: Yes.

MR GOUGH: So plus I can't even ring out from Wilcannia. I can't even get even get Netflix at home (indistinct words). So maybe with some little - as the time develops.

PROF KING: You mean you're not on the NBN?

MR GOUGH: No.

UNIDENTIFIED SPEAKER: (Indistinct) don't want that.

MR GOUGH: We're still on dial up.

PROF KING: I want to ask Des about, you know - just if you can comment on Peter saying look it might be different for indigenous communities and some other communities I expect and because of that need for a rapport, and then I want to run a model past you that we've seen elsewhere and see your views on that and then I think we probably better grab a coffee. Des, what's your view on - so about Telehealth that - - -

MR JONES: Well to me they'll (indistinct words) for all the suicide cases that have happened, did they have access to a mobile phone. Did they (indistinct) mobile phones. Is that - you know what I mean? So I think it's more - it's more the educational stuff around Facebook is out there - around the stigma with mental health and supporting the family unit because the family unit is the first responder. That's - they're first one that really respond to episodes and whatever, they're in the family area I suppose of that environment. But I think it's understanding, because that to me when it explodes it's not because of that there and then, something happened previously or something that's happened a while ago, you know, so it's not - to me they just - it's a trigger, some little trigger that triggers an episode and it might not be coming to this meeting, it might have been something that happened somewhere else.

PROF KING: Yes.

MR JONES: Come here and something sets up and it's just exploded and that's (indistinct), but as I've said I'm no expert in that field but observing it all you think a lot of this can be prevented by engaging with family. Educate the family around what mental health and you know the things - behaviours that can trigger episodes. You know what I mean?

PROF KING: Yes.

MR JONES: So, I mean technology is important. A lot of people understand technology and how to use it, unfortunately some will be using it the wrong way, but I think it's about trying to strengthen the person and the family first, you know?

PROF KING: Yes.

MR JONES: So they don't feel isolated because I mean (indistinct words) isolated straight away. So I think the family understanding what's going on as well.

PROF KING: Yes.

MR JONES: Because if you don't understand - if you never been - - -

PROF KING: Family, yes.

MR JONES: - - - (indistinct) got no idea what's going on, you know?

PROF KING: Yes.

MR JONES: So your first call is (indistinct words) but there may be other ways of doing it. I mean technology is great, but not everything else is going to - you know, a computer, you know, or access to that, they rely on their social workers or their community workers that are on the ground all the time. So I think just beefing up that communication (indistinct words) for those who access (indistinct), what's on the - you know, what you Google nowadays. I mean you can Google and have a look at it but there's no emotional thing on (indistinct), I mean.

PROF KING: Yes.

MR JONES: It sort of doesn't - nothing better than a hand on the shoulder and say "you okay?" you know?

PROF KING: Yes.

MR JONES: You can't get that from technology, you know.

PROF KING: Yes, from the screen, yes.

MR JONES: So we need to fix that side up, that's the human side I suppose.

PROF KING: Yes. Can I just run past - because I don't know if you've got anything equivalent here so I'll just be interested in your views, and then we might take a break. We started to get into areas which relate to suicide prevention and I'd like to touch on that after you grab a coffee. There's a group out of Toowoomba who - Frontiers? What's it called? No, Rosalyn is looking at me blankly, she can't remember a name either. She's not sure which one I'm talking about.

MS BELL: (Indistinct words).

PROF KING: Sorry?

MS BELL: Outback (indistinct).

PROF KING: Outback - yes. Sorry, I can't remember the name of the service, but we actually visited them, I think it was Longreach when they had the floods there. It must have been February this year. So they'd gone from drought - I remember they'd gone from drought to flood. So, you know, people who had managed to keep their stock alive, all of a sudden their stock were drowning to death, and they actually worked on a model where they sort of had the counsellors and when there was an incident and when there was a need they'd fly the

counsellors out. So they'd literally fill up a charter plane, fly the counsellor, get into the community, talk with people in the community. Set up relationships over a period of a couple of weeks and then continue on through using things like Telehealth and using the technology.

So I guess one thing - Outback Futures. Thank you. So we were both right. I thought it had outback in it, and you thought it had futures in it. So I was wondering is there anything equivalent here? Would that be a service that would be worth thinking about - okay.

MS LATHAM: Hello, my name is Vanessa.

PROF KING: Sorry. You have to come up to the table though because - - -

MS LATHAM: Okay.

PROF KING: But bring a chair up. Bring a chair up.

MS LATHAM: (Indistinct words).

PROF KING: It's purely that it's on the transcript, so - - -

MS LATHAM: My name is Vanessa, I'm the manager of mental health, drug and alcohol services for the Royal Flying Doctor Service here. So we have a base here in Broken Hill.

PROF KING: Yes.

MS LATHAM: And regularly fly out to - it's about 17 or 18 sites in the far west, a little bit into Queensland and South Australia.

PROF KING: Yes.

MS LATHAM: With a GP, dental services, mental health, drug and alcohol. So we fly in and work from New South Wales health facilities in the little towns, Tibooburra, Wilcannia and Menindee or into station properties or really small towns and just set up the clinic there.

PROF KING: Yes.

MS LATHAM: So the mental health side of that's being going for about 10 years. So - and I guess we do use a lot of telephone kind of to support the face to face. Some places we only get to once a month. Other places we get to once a week. So that's quite good. I'm not sure really what else - I think we can't really replace the human person to person contact, but I think the telepsychiatry at that very acute (indistinct) level is wonderful that we have that, but yes all the levels kind of up - - -

PROF KING: (Indistinct).

MS LATHAM: - - - to there. That human to human kind of contact, and I guess another big thing we're doing at the moment in partnership with Lifeline is identifying - this is drought funding, so identifying pastoralists at the moment living on the stations and giving them basic

training. But these are people that are already - they're already kind of demonstrating their advocacy in mental health, putting themselves out there and they're already supporting their peers and we're supporting them to keep doing that.

PROF KING: Yes.

MS LATHAM: Giving them basic training like that (indistinct) counselling, and a few other Lifeline provided courses, and I guess just trying to really build that - the capacity of the - and a workforce of people living out there, and so probably looking ahead just different training and development opportunity with all of our local services to give that opportunity to different community members, different cultures. I think that's probably a big investment sort of - and partnership opportunity we can all continue with. Don't know, do you want to add anything else, either of you?

PROF KING: But it's interesting in some ways, I'm not sure if you were here at the beginning but we've sort of come a full circle in that we were thinking, you know, well started off in schools, need to help kids, get training in resilience in social and emotional wellbeing, those sorts of things, and really what you're almost saying is well it doesn't stop at school level when - you know, when you've got communities where you know there's going to be stress perhaps due to drought, perhaps due to other factors, trauma, I know there's been a number of suicides here so I suspect there's communities in stress around Broken Hill at the moment.

What you sort of want to do is actually have people trained on the ground, not as clinicians, but with enough training so that they're able to at least provide an effective doorway for someone to be able to say, yes, you know, the are you okay but not, you know - the problem with the are you okay sort of approach is what happens when they say no?

MS LATHAM: Yes.

PROF KING: And you're saying well, yes, we're training to train people so that if someone says "no, I'm not okay" they're actually able to do something. They're able to respond but perhaps (indistinct) - - -

MS CROSSING: Can I - sorry, I'm Kayelene, I'm counsellor, Warra Warra Legal.

PROF KING: Yes.

MS CROSSING: So Aboriginal legal service. I'm actually a mental health first aider trainer. So I go into communities and deliver mental health first aid training.

PROF KING: Yes.

MS CROSSING: To community members, so they're able to counsel each other I guess when we're not around, which in the New Year I'll be - I'm only new in my position, a week new.

PROF KING: Yes.

MS CROSSING: And I also used to work at Maari Ma as well, so I've got a lot of experience within the community as well.

PROF KING: Yes.

MS CROSSING: So delivering that, yes, training I guess is giving the hands on, so Bob Smith down the corner can actually give that first initial I guess one and one accidental counselling to be able to get - and then get supports in straight after that.

PROF KING: Yes. Any feedback on how well that works?

MS CROSSING: I've only run a few courses myself.

PROF KING: Yes.

MS CROSSING: But the statistics show that it does help to an extent. I guess it's a matter of if they're wanting to help that person or not as well, so - but I deliver it to a lot of other service providers as well so it's - and then, yes, a bit more, like I want to go into the schools and do it with the teachers but it's a matter of getting the teachers two days free.

PROF KING: Yes.

MS CROSSING: It's a two day full course.

PROF KING: To be able to train - - -

MS CROSSING: Yes.

PROF KING: Yes. Okay. Look we'll break for coffee. So thank you very much for that, and apologise for the formality of having to come up to the table, it's because of the transcript. So if you're not at the table the transcript can't capture the comments. So let's have a break for 10 minutes and pop back in. Thanks.

SHORT ADJOURNMENT

RESUMED

PROF KING: Okay, a couple of things that I'd like to get onto now. I'd like to talk a bit about suicide prevention, issues of suicide, what we need to do to - lots and lots have been done in suicide prevention in this country over the last 10 years and the rate hasn't dropped. So clearly whatever we're doing isn't working. So I'd like to get some ideas, what you think might work in Broken Hill and all the rest.

Issues of stigma, we haven't really talked about that yet, so I'd like to have a bit of (indistinct) there. Some workforce issues, I think Jennie and - sorry, someone else was wanting to talk a

bit about workforce issues and mental health nurses and so on. So let's head in that direction. As I said at the beginning, if you do want to speak, feel free to just pop down, grab a chair if there's a chair free, or drag your chair down. But you do have to state your name and come down here to make a comment. And I suspect I'll probably – Henry's probably running around like sort of saying, 'No, all these people need to register, and so on,' which (indistinct).

Now, Des, we had a chat over morning tea, then. Did you want to make a couple of comments to start us off?

MR JONES: Just on the technology.

PROF KING: Yes.

MR JONES: And like I said to Stephen, what's happening today is a lot of young people are – they haven't got wi-fi, access to it. They would go to a spot where there is wi-fi, it might be a supermarket or places that have it. But they're moved on because of the perceived risk or whatever it is. And I think, you know, that affects a lot of them, because there are – they're moved on, or the police are – someone, if a shopkeeper rings up, that they have to move them on.

PROF KING: Yes.

MR JONES: And the kids are saying to the police, we're only here for the wi-fi, you know? But there's been a call obviously. So in that technology, there may be an opportunity to put those wi-fi locations in safe places, you know, or such or you know, where the kids can put up – not only the kids. A lot of adults haven't got it, you know, but they get a signal. They'll hone in on that signal and they'll stay there, you know, so there might be an opportunity to do something around how we utilise wi-fi with our services.

MS HAYMAN: And Des, they used to have drop-in centres in Broken Hill and things like that. They've slowly but surely completely got rid of anything like that. So kids have got nowhere else to go, especially on weekends.

I know one of the clubs around town, they were trying to run something on Friday night a while ago, but that obviously never got up. Or got (indistinct) or anything so that's probably one of the biggest problems we've got is the kids have got nothing to do. So yeah, they do try to find where this wi-fi is and then the business owners don't want them there.

PROF KING: Yes.

MS HAYMAN: Drop-in centres, something similar to a drop-in centre would be a really good idea.

PROF KING: Yes.

DR NACHIAPPAN: I suppose like your old-fashioned internet cafes in the early days.

MS HAYMAN: Yes.

DR NACHIAPPAN: Back in those days, I actually went there. If I couldn't get access to them then I wouldn't have had any internet. Whereas now everyone's got it on their mobile phones, but those who can't afford it and in a region like Broken Hill, I think approximately half our community does not have internet access that they ought to which is very prudent.

PROF KING: Sorry, Ramu, because otherwise the transcript guy's going to get very upset. If you could just state your name for the transcript?

DR NACHIAPPAN: Yes. Ramu Nachiappan, I'm a GP in Broken Hill.

PROF KING: Thank you.

MR WHITE: Please - - -

PROF KING: Yes?

MR WHITE: Drop-in centres were mentioned.

PROF KING: Yes.

MR WHITE: Uniting Church at the moment, and has done for probably the last 15 or more years, maybe even longer than that, they've run a drop-in centre. It's still running at the back of Wesley Church. You've got a guy that faithfully goes in there four days a week in the afternoons, sits there and waits for the people to come in, have a chat, have a cuppa, watch TV's and just spend some time. A safe place. And he's got one guy that comes in there that occasionally has mental problems and he's just there. He's made himself available for that many years. His mother used to do it as well. And he's – he used to do it with his mother and now he just does it. He just sits there. So there is a drop-in centre there, but there – it used to be in Argent Street and now it's moved up there behind the Wesley Church. But that's the sort of places we need, like - - -

PROF KING: Yes, community spaces.

MR WHITE: Like St Vinnie's for the meals and of course, that's – that'd be a good place as well (indistinct) but we do have places like Lifeline itself where people can go in and have face to face. Like we said before having someone sitting opposite you talking to you, looking you in the eye and putting a hand on your shoulder and just saying, you know, that's so much better than, like we see, technology. Technology can only do a certain amount. But we need to have that face to face and people there listening to you, you know?

PROF KING: So the other thing, just on the technology side, so again, some of you were talking to me over morning tea on that. One of the things that people have said to us again, what – mainly out bush where wi-fi can be pretty patchy, it's sort of saying well, if you have the internet technology and you want, you know, even if you've done the initial face to face, but then you want to do online counselling follow ups, need somewhere, you know, private that you can do that. So just thoughts on that, is there anything like that in Broken Hill?

MR WHITE: Yes, Lifeline.

PROF KING: So Lifeline. Okay. So, yes?

MR WHITE: That's what Lifeline is about here in Broken Hill at the moment. Different services. And of course, we do have that service where people can come in and privately, in soundproof rooms, sit there and feel free to actually - - -

PROF KING: Can they talk to any counsellor? Or just a Lifeline counsellor?

MS HAYMAN: No, just the Lifeline counsellor.

MR WHITE: Just the Lifeline's, yeah.

PROF KING: Yes, so if it was a – if you'd – say through the Royal Flying Doctor Service, you're being linked up with somebody but they weren't a Lifeline counsellor then, that you wouldn't be able to use the Lifeline facilities? Is that - - -

MS HAYMAN: That's something - - -

MS PICKETT: Sorry. I'll talk about that, sorry.

MR WHITE: Yes, good girl.

PROF KING: Yes, please. Come up, state name and - - -

MS PICKETT: Sorry, Marisa Pickett from Lifeline. We've got a great relationship with health and the RFDS, so we do work as a community. So we do have our Lifeline counsellors. But we're very happy if kids want to go out to the RFDS we can chat with Christy or Jodie, like, it's very much – we're not isolating people just to us.

PROF KING: Yes.

MS PICKETT: It's really a connection centre. So we're connecting to where will suit them best. So they might come in, have a chat with one of our counsellors. That will evaluate whether they can help them or if somebody's better off going elsewhere.

PROF KING: Okay.

MS PICKETT: Yes. Just on the technology. Lifeline Australia has just done a tech service. They've been trying it for three years and they've – it's from six – it was originally 6 until 10 at night, so people could text through. They've now extended it until 6 until midnight because of the demand. But what I found really interesting, we had Lifeline Australia vettings last week.

And they said 40 per cent of people texting said that they would never have picked up the call. So texting (indistinct).

PROF KING: Okay. Yes.

MS PICKETT: So I think you've got to remember we're all busy these days.

PROF KING: Yes.

MS PICKETT: And we don't always have privacy to make a call. Some people are lurking or doing something, it's – and they're feeling really crap. A quick text, so - - -

PROF KING: Does Lifeline have any data relating to that that we could use? Because what you're saying actually fits in completely with what we've heard elsewhere where people have said well, when you're talking about technology, you've got to think of, you know, phone, text, face to face, you know, just typing an email sort of thing. That – so you've got to think of all sorts of different ways that people react with technology and you know, so the suggestion was put to us, well, young people in particular, they want to text. They don't want to be doing a face to face Skype call. So does Lifeline have any data or anything?

MS PICKETT: They're just now getting all that data together. So it's been a pilot program for three years. And they've just – now the data's coming through. So they would be happy to share that.

PROF KING: That'd be fantastic. Because, yes, again, that – you know.

MS PICKETT: Well, they realised – as I said, it was a trial from 6 to 10 and the demand was huge. So it's now 6 until midnight. But you've also got to remember Lifeline doesn't (indistinct) funds. So we do a lot of this just with little dribs and drabs and so for us locally, because we've got a great relationship with Health and RFDS, you know, they support us in a lot of the ideas that we come up with. You know, so.

PROF KING: Yes. I think - - -

MS McMANUS: So, just on technology.

PROF KING: Yes.

MS McMANUS: (Indistinct) face to face is better at (indistinct) relationship, but then there are times where we require specialist services that were just not going to be able to get face to face in Broken Hill. So there are times when Telehealth is important. But I think that we know that there are evidence-based CPT programs. We know that they exist. What I think is that people aren't going to just go and join those off their own bat. Often it takes a special type of self-disciplined person to do that.

And I think you need a connection with a mental health clinician first who introduces the consumer to that program and maybe even sits with them for the first one and says, 'This is what can happen, this is why it's helpful,' or whatever. And then possibly offers a space for that to continue if that person doesn't have internet access at home or, you know, so I think that the connection needs to occur first, but yes, it would be great if we had the technology and the

rooms, the private rooms where that person says, okay, yes, I'll come back this time, this day and we'll do the second session of this online program.

PROF KING: Yes.

MS McMANUS: I think that – we've – I feel like I've said to a lot of people, here's a list of online programs that could be helpful and I – I've really (indistinct) that people go away and complete those.

PROF KING: So the gold standard as far as we can tell in this – in Australia, is a WA1, which is called Ports which is built off Linespot which some of you may have heard of, is an online program. But it works on the basis of generally the GP's the gateway. The GP says, 'Look, yes, you might have had some mild panic attacks, mild anxiety, you know, a bit of symptoms of depression.' The GP in essence refers you to the website and the initial approach en force is that it's not you go in and there's some engine that does it. They actually have psychologist at – you can communicate in any way you like. So it can be phone and it can be text or whatever, and there's a triage done. And they then do a proper triage to work out well, are the online services going to be able to help you? Or no, there's something more happening here.

Do you need to be referred in the community and then they will do the referral. Sorry, so I've now forgotten where I was heading with that.

MS McMANUS: Yes. So in some ways that keeps the consumer on track, because you've got a real live person saying 'This is what we're going to do next.'

PROF KING: Yes. And I'm not sure, have they done – have they publically released the evaluation, yet?

MS McMANUS: I don't think so.

MR WILLIAMS: There's an (indistinct) paper published.

PROF KING: It has been published?

MR WILLIAMS: Yes.

PROF KING: Yes. The evaluation though?

MR WILLIAMS: Yes, they're evaluating the program.

PROF KING: Evaluating the program, yes. So it seems to be pretty successful.

MS McMANUS: And again, it's not going to fit every consumer and it's still going to – still targeting, sometimes I think your higher level functioning people that are going to understand a CBT paced program as opposed to your more young person that's experienced trauma that needs a connection with somebody and that's what they need. So I guess it's up to the service to be able to recognise the needs of that person (indistinct).

PROF KING: Yes, it's making sure the right people have the access to the right services. So – and have a choice about how they want to interact with those services.

MS OSMAN: Sorry.

PROF KING: Please.

MS OSMAN: Emma Osman with the RFDS. I work on the peer support community mental health program We've Got Your Back that Vanessa referenced earlier. I was a consumer, I lived up near Cameron Corner. Just touching on technology, as you said, NBN and internet capabilities. At the lower end of the spectrum, I looked at doing relaxation and mindfulness courses while I was there. I didn't actually have the data allowance and bandwidth to participate in those programs.

PROF KING: Yes.

MS OLSEN: You know, I was capped at 60GB per month, that was it, and that was to service myself, husband, business, workers, everyone.

PROF KING: Yes.

MS OLSEN: I know that is now expanding, they're coming a long way with that, but it is still very much a problem for people out there.

PROF KING: Yes.

MS OLSEN: Again, I agree that it is fantastic at the acute end that we do have services available, but I believe again that it takes that connection with a peer or an appropriate worker, or a nurse at the hospital to explain to someone what that looks like. Because you're dealing with also – I can only speak probably from my consumer experience as a person living out there. You've got a portion of the population that still really isn't actually that comfortable with technology. And so if you're saying to someone, "Come in and" – you know, you really need that trust and that relationship with a person on the ground to get them to come into a conference room and feel secure, and feel like it is an appropriate thing for them to be speaking to a clinician on a computer screen.

So again, like we've said that connection and that enabling and that linkage between – that human linkage between a consumer and a service is what I think is going to help technology work, yes.

MS McMANUS: And if it's that – if it's your GP that makes the referral, then there needs to be a clear navigator in that GP service that actually takes the next step.

PROF KING: Yes.

MS McMANUS: Because obviously your GP's not going to be funded to sit and do that. So your care navigator that is able to support the next steps.

DR NACHIAPPAN: If I can just add to that, since we've talked about funding and the lack of funding. We're all in this room because funding is one of the issues in mental health, and I think no matter how much money you throw at mental health services, it hasn't made the (indistinct) difference the last few decades. So I'll just thought I'd - - -

PROF KING: Yes.

DR NACHIAPPAN: - - - put some of my thoughts into this. In the first reform that you propose, I think workplaces need support, like for example, you've got a workplace rep for the union. I think we need workplace reps for mental health and welfare. You actually need an individual in a workplace who takes responsibility – for example, a lot of people say, "HR does that, don't they?" Well who trusts HR? People are frightened that they're going to get the sack if they go to HR. They say, "I've got a problem with my child or my dog." They don't say – that's the next one, (indistinct) the problem case. So you really need, I think, like a coordinator or a person designated, responsible for mental health and wellbeing of the staff.

So the other comment I wanted to make was funding. General practices are funded by the click-clack Medicare rebate.

PROF KING: Yes.

DR NACHIAPPAN: Which is woefully – I want to say inadequate. I don't think that's the right term – mismatched for current times.

PROF KING: Yes.

DR NACHIAPPAN: Thirty years ago when Gough brought it out, people thought it was the best recipe in the world. But Gough's long gone, and Australia's changed, and he got the sack, despite being a popular prime minister, and (indistinct). To cut a long story short, instead of getting too much into politics, you need to fund general practices in a different manner. Not just click-clack Medicare. Perhaps fund them with paying the salary of a mental health staff member. Don't give them a fistful of cash, give them an employee. Tell them you can employ someone, the government will pay for it. So isn't that a different way of reinventing the wheel?

PROF KING: So there was actually a program that was doing that, which was funding mental health service in GP clinics.

DR NACHIAPPAN: Yes.

PROF KING: Which then got defunded.

DR NACHIAPPAN: Yes.

PROF KING: But any experience – is that the sort of thing that we need to actually do properly?

DR NACHIAPPAN: I've been in this town for a little while. So in that time, some of these programs have come and gone. That mental health nurse program was a good one, but there were not many mental health services in Broken Hill at the time.

PROF KING: Okay, yes, they didn't – yes.

DR NACHIAPPAN: So we did attract nurses who were interested in mental health, but if they didn't get a credential and get their pieces of paper, which was stamped by the regulator in time, that the money was lost, the opportunity lost, the jobs were gone. So Lifeline is the best example, I think, of having people who don't need paper qualifications, who can make a huge difference in society. The same can apply in general practice. You don't have to be a mental health (indistinct).

PROF KING: Yes.

DR NACHIAPPAN: You don't have to be a GP with special mental health skills. Someone who's interested in that area can work in that environment, in primary care.

MS HAYMAN: You're talking peer support. Peer support.

DR NACHIAPPAN: Sure.

PROF KING: Well it can be peer support. It wouldn't, as I understand what I was saying, it doesn't have to be a peer, also someone with lived experience, that's somebody who has the relevant – the relevant skills aren't necessarily a bit of paper.

DR NACHIAPPAN: Yes, yes. Relevant experience, relevant interest, relevant enthusiasm to make a difference. And some of the best people in mental health are not necessarily the ones with two or three PhDs or multiple masters programs. They're not. So they're people who are enthusiastic about contributing in that environment. A clinician, like the mental health team, and the hospital. They're not all psychologists, in fact, there are very few psychologists on the mental health team. So it can be a social worker, it can be an OT, it can be a nurse. It can be someone - - -

MS OLSEN: Graduate counsellor.

DR NACHIAPPAN: Yes, exactly. So I think we need to look outside the square, and Medicare click-clack isn't the answer with general practice. It needs to be a funded clinician position, and if you attract someone appropriate, why not? It will make a difference to communities (indistinct).

MS SANDERSON: So I'd like to just follow – Joan. I'd like to just follow on from that. Like part of what I'm doing that at the moment is advocating that counsellors can get the medical – be on the medical benefits scheme. And like I was telling the girls at Lifeline just recently, this is a little story. I saw on TV in Queensland how people were having trouble with - snakes were actually getting into their pool, and they were getting in there and they couldn't get out, and they were drowning. So they said to the people, just put a rope in the pool and attach it to something so the snakes can come in, and they can have a drink and then go out.

PROF KING: Yes.

MS SANDERSON: And that's what counsellors do. Like sometimes we're that rope that stops people from drowning. And you know, you were saying before about that gap. There's a huge gap. You know, we can't do what psychologists do, and we don't even – you know, we don't even pretend we do. But the role of a counsellor is very important.

Like in my private practice, I don't – I don't even have to advertise, and I'm – like I'm nearly full.

PROF KING: Yes.

MS SANDERSON: Like with people. And so like, you know, I'd like to think that I provide that rope so people can come in, and they don't end up with full blown psychosis or whatever, because you're dealing with things in the early stages. I'm working with kids, and you know, right through so you're actually – like getting them to tap into the richness they've already got in them, so they can actually find ways of coping with things.

And like, if we all try and have to be – you know, trying to work out how we're going to make a living doing – this should be something that's guaranteed. You know, for counsellors, our role is important, and counsellors are working right throughout Australia in so many professions, and they're recognised like that. And you know, I think sometimes psychologists – and this has come from psychologists have told me this – they feel threatened. But we've all got a place, you know, we've all got a role to do, and a counsellor's role is just as important as a psychologist's. And statistically, there is no evidence that says that going to a psychologist makes a person any better than somebody who's seeing a counsellor.

MS McMANUS: As a psychologist, I can say that I cannot understand why there's a Medicare rebate for psychologists, and not for counsellors. Like, and that's coming from a psychologist. I do not understand why that is.

MS SANDERSON: So and unless this changes, like you know, we – as I said to you before, we have got people dying, you know, taking their own lives because they can't get in to see people. Or when – sometimes when they go to the hospital, the things that people say to me is like, every time I go there, I see a different counsellor, and I myself, if I was going to the doctor and I had to see a different doctor every time, I would be – I don't think there's anybody in this room that would want to do that, but we're asking mental health patients to actually go and see a different person.

And like, I might see somebody one week and I'll just pick up on something so I'll write it down in a note, and then the next time they come, I'll take them back to revisit. But if you're just checking on notes from another person that's looked at them the week before, how can you tell what you've already heard from that person? I just think that we have to look at – you know, this is a huge void. And I'm not – you're saying that there's a lot of psychologists in Australia. Well I'm hearing from family members in South Australia and Victoria that they can't get in to see psychologists, there's such a waiting list, and in the meantime some of them will end up in mental health facilities because they just can't get the help. So, you know we need to take our

blinkers off and start looking at the reality, you know, that counsellors have a huge impact in the lives of people, you know, so - - -

PROF KING: So our recommendation - so I mentioned the missing middle before, so let me just run through what our idea is. So you've got the psychologists and just reminded me on that I was going to ask is there any community psychologist practices in Broken Hill, but I'll come back to that. You've got the psychologists who should be trained in a range of therapies, not just CBT which is formally the one they can do it, but you mentioned Dialectical Behavioral Therapy. There's a range of other - what is it? The one that's specifically for trauma, eye movement (indistinct) - - -

UNIDENTIFIED SPEAKERS: (Indistinct words).

PROF KING: Yes, thank you. I'm not a psychologist you can tell, but there are a range in the sense of often new therapies and yet our psychological workforce seems to be spending most of the time under MBS dealing with mild and moderate anxiety and depression. So our idea is to say, hang on, you've got this trained workforce, you've got a huge service gap for people who are subacute, they're not going to emergency yet, we want a workforce to keep them out of emergency, right let's take the psychologists and bang them down there. And whether that's done through Medicare or whether that's done through some other funding arrangement, they're meant to have the training to deal with these people, the clinical evaluations are that they can deal with the issues of more serious anxiety, depression, borderline personality, bipolar (indistinct) and help people stabilise (indistinct).

But of course that then leads to a service gap down here because, you know, you now need people to be able to deal with anxiety and depression. So one possibility - you know, there's a range of possibilities can fill that gap. One possibility that we didn't look at in our draft report is whether the counsellors have a role in there. Whether again it's something like counsellors working in GP practices. I have quite openly said - because we've heard from counsellors around Australia who've said "oh, just give us the Medicare provider number, let us go through Medicare" and the road will be paved with gold and life will be wonderful, and I say, one, I think that's unrealistic. I would be very surprised if the government is willing to have more people under the MBS and as the GPs can say even if you get MBS provider numbers you then tend to have (indistinct) caps put on as you see with Better Access, the psychological one.

So I'd really like to understand can - I think the first one is should go to (indistinct) but I'll ask it anyway, can counsellors help fill that gap for mild anxiety, depression in a sense before they need to see, you know, the more highly trained clinician? And secondly how should - you know, is MBS the only way that can be funded or are there alternative models that we should be looking at?

MR GOUGH: Stephen, if I could just - sorry.

PROF KING: Please.

MR GOUGH: Peter. Sorry. Having worked as a counsellor for many years prior to (indistinct), I find that most clinicians, psychologists, counsellors, will pick the (indistinct).

PROF KING: Yes, I know.

MR GOUGH: So why would anybody come to Broken Hill, this high levels of skills when they can get paid for doing easy work in the cities (indistinct) - - -

PROF KING: Yes, which is the psychologists aren't out here.

MR GOUGH: By easy work, I mean the typical "I've got my kids a bit anxious at school" - - -

PROF KING: Yes.

MR GOUGH: - - - or "I'm not getting enough sleep". I don't mean to denigrate that but we are dealing with trauma day in, day out, working our (indistinct) out.

PROF KING: Yes.

MR GOUGH: Getting paid the same. So I'm here as an older person now, because probably my time would be back a bit.

PROF KING: Yes.

MR GOUGH: Plus I like the outback.

PROF KING: Yes.

MR GOUGH: There's not many of us around. Now (Indistinct) is born and bred here. One of the GPs up there is born and bred here.

PROF KING: Yes.

MR GOUGH: So they love it as well, and the doctor over here as well. So what incentives, apart from an MBS, can bring people here?

PROF KING: Except we know the MBS doesn't bring people here.

MR GOUGH: Correct.

PROF KING: Which is why I wanted to ask are there any community psychology practices because if you look at the map, we've actually got the heat map of where the psychologists are and where Better Access - which is the psychologists program under MBS - where that's accessed in Australia.

MR GOUGH: If I can just tell a quick story? (Indistinct words) down in (indistinct), but my clinical (indistinct) was overworked. She was booked out three or four months in advance. So she put her fees in a country town, it's \$350 now, with \$128 rebate.

PROF KING: Madness.

MR GOUGH: Her list did not go down, and people just paid more.

MS McMANUS: And that (indistinct) - that's the target population then isn't it? (Indistinct words)

MR GOUGH: So why should she come out here and get less?

MS McMANUS: (Indistinct)

MR GOUGH: In a less challenging environment as it were with less trauma, less suicides - - -

PROF KING: So how do we answer that? So we've got the counsellors, but also I agree the psychologists they're all in Melbourne, Sydney, Brisbane - - -

MR GOUGH: I'm glad you asked. Okay. We in Maari Ma has a number of overseas doctors.

PROF KING: Yes.

MR GOUGH: Part of their registration in Australia they must do - I'm not sure of the exact numbers, a couple of years in the bush. Why doesn't that work the same for psychologists? Or nurses coming in from England or Asia or wherever. If you want to work in Australia and be a professional person as an Australian you must go to the bush, just like the doctors. Highly skilled doctors, you know I'm talking about, so we get the benefit of them for two years without (indistinct) where they develop their skills. But also some of them love it here.

PROF KING: Yes and stay.

MR GOUGH: And they stay. Our program down there is a lot of locums. I came out here as a provisional psychologist as a locum.

PROF KING: Yes.

MR GOUGH: And the said, "Would you like to stay?" I said, "Great".

PROF KING: Yes.

MR GOUGH: Those sorts of programs need to happen because it's a bit like wine tasting, try before you buy.

PROF KING: Yes.

MR GOUGH: Nobody is going to speculate and come out to Wilcannia or Menindee or Broken Hill just on a whim.

PROF KING: Yes.

MR GOUGH: They need to come out here and immerse themselves in the amazing culture, the amazing history of the place and go "oh, we might just stay a little bit longer". So I don't

think it's a financial benefit, although there will probably be that. I think it's an immersion and family that experiential thing that people especially overseas nurses, doctors and psychologists, anybody.

PROF KING: So I'm going to push you bit on this because you've gone into one of my favourite areas. Does it have to just be overseas? So if you were training as a doctor in Australia, a number of universities require that you do rural placements (indistinct words).

MR GOUGH: I'm glad you ask. My stepson is in his second year at University of Queensland doing medicine. So he's already got his hospitals, Blackwater and Rockhampton, I think.

PROF KING: Yes.

MR GOUGH: And two years. As a provisional psychologist, as an older person now, the whole world of psychology is designed for rich (indistinct) city people, because it's six years of training. The last two years of internship you don't get paid. So how can a middle aged person with families and houses afford to do this. So I was lucky I've got, you know, a very forgiving partner. So in this provisional period why not pay these people to come out and finish their internship. Just like they do with doctors. So pay it if you come out to the bush. So if you stay in the city well that's your (indistinct) but if you come past the divide, you will get paid and you will get all your supervision and your qualifications and hours provided for you, and for young people to be here for two years there's every chance that they're going to form relationships, sport, community ties and stay.

MS SMITH: Vanessa here. I was just going to say I think you touched on the idea that they - you know, they choose to stay in the city because it's not so demanding. So for some people that can be quite confronting and a bit scary about working with, you know, particular people. So I think having access to really good professional support. So people may choose not to come to this - sort of this because they don't have that sort of collegial relationship within their profession. So, you know, once there's a critical mass then, you know, they will come.

MR GOUGH: (Indistinct words) or their co-worker. Whereas the scales need to be tipped. So I mean there's a brain's trust in this room that I'm sure if there was a new clinician, counsellor, nurse, whatever, we'd go in behind them and support them, and could be in cheaper accommodation, could be a provision of - I know we get salary sacrificing out here for NGOs, but that professional support is vital and we've got plenty of professionals here.

MS SANDERSON: Can I just say - Joanie - like the RCAP have put out a lot of information in (indistinct) counsellors, and they're saying that 2.7 billion would deliver 4.5 billion dollars in savings. So the money that you would actually help to support counsellors working out in the small communities would actually save the money - save the government money, and like I'm sitting here listening and like I'm 71 years of age and it's not about money for me. It's making a difference in the lives of people, so you know if we don't take our rose coloured glasses off and start looking at the reality out here, like, in my practice I'm not just working with people who've got a small anxiety, I've been working with people right from the highest level of trauma right down, you know, and they're being helped, you know, and it's about making a difference in the lives of people. You know, it's not just a job, it's actually, you know, you make a difference in the lives of a family and you change the next five generations. You

know, and that's where I come from and, you know, there's all this theorising but we've got to face the reality that being able to provide people with the medical benefits scheme for counsellors would make a difference in the lives of families.

You know, I said to you before, it's not because I want to big note myself, but if somebody comes and they can't afford it that I'll work with them for nothing. I'm not going to turn people away because - - -

PROF KING: I think the conversation goes exactly what - you're saying it's just not money.

MS SANDERSON: Yes.

PROF KING: You almost need to try before you buy actually.

MS SANDERSON: I know, but I know we need to get people out hearing (indistinct) person, you know, while we're talking about this, how many people in this city are thinking about killing themselves today because they mightn't feel comfortable in going somewhere and getting help.

MR WHITE: Yes.

MS SANDERSON: You know, three in the last two weeks have died and that's three too many.

PROF KING: Yes.

MS SANDERSON: You know, how much longer are you going to have this policy and that policy and, you know, all these theorising. We've got to start doing something because people are dying, you know, families are being affected every single day by, you know, what's happening in their lives. This is real, this is stuff on the ground. You know?

MS SMITH: I think that's why we're all here.

MS SANDERSON: Yes, so, you know, need to just be, like, saying, well, you know, there's all these sort of politics in the city and there won't be any hope of doing that, but if the needs aren't being met by the people that are in that gap, then what do we have to do? Even in the cities, you know, but - - -

MR GOUGH: Get people here. You know, I think the problem you say - - -

PROF KING: Sorry.

MR GOUGH: Sorry, Peter. It's absolutely agreed, but we haven't got enough so how are we going to get more?

MS SANDERSON: Yes.

MR GOUGH: And just to throw on from that, and I might have spoken early to Steve about this, is that I look around the room and a fairly Indigenous population in the West, how many Indigenous counsellors are here? How many specific to male trauma are here? How many female traumas are here; trauma counsellors? Whereas, no disrespect to people here, we're probably on the older side than the younger side. How do we get young people to deal with our younger population? You know, it's got to be these incentives that, yes, there's money in NBS and all that. They're not turning up because each town they come to from Sydney, they're dropping off and they don't get here.

So we have to work out a way, through incentives, through even fast tracking some qualifications because they get their fair share there, to give people, just like the doctors we work with, if you're going to come to Australia, you've got to go bush. But that little - a big story about Pyramid Hill; the town died so they imported all of the workers that worked there in their pet food factory, and now it's the most prosperous, fastest growing town in Victoria because they had a structure where they took people, put them in the bush and they loved it.

PROF KING: A couple of people up the back wanted to - - -

MS OSMAN: I just want to touch on workforce retention.

PROF KING: Sorry; just again, name for the transcript.

MS OSMAN: Sorry. Emma (indistinct). Just wanted to touch on the UDRH the University Departments of Rural Health.

PROF KING: Yes.

MS OSMAN: It's supported throughout Australia, and that is that concept. Brings students out to a rural area and you have that served into - you know, you can take the fish so to speak - who will have the experience and they will come out and they will practice as clinicians.

You've also got the CUC - Country University Centres that are about people that are studying remotely, giving them a centre and the technology. They've got great internet connection there, they've have telecommunication, you know, video conferencing facilities, they've got tutors. I think that's really important is making it accessible and affordable for local workforce to upskill. So if you have a counsellor so, like you said, enable them to become a psychologist if they like, have the programs with the resources and then give the individual the financial means to continue their life and step-up into that role within their community if it's not actually enticing people to come out. So it's a double-sided thing. I think it's, yes, as you said, education and - - -

PROF KING: I totally agree.

MS OSMAN: Yes.

MR GOUGH: Just on that; University of Melbourne have got a rural health centre in Shepparton, one and a half hours from Melbourne.

PROF KING: Monash have in Mildura.

MR GOUGH: Like, we do a lot of work with universities from everywhere.

PROF KING: And on that last point, I did a pharmacy inquiry a few years ago, which was interesting. Pharmacy is an interesting area, some of the regulations there. But one of the interesting parts we went out to Wagga. We expected to hear from Wagga what we heard, you know, travelling around, we went out well and truly out bush; we went to Fitzroy Crossing and so covered a lot of Australia.

Pretty much everywhere out of the cities was we don't have enough pharmacists, you know, it's impossible to get pharmacists. We went to Wagga and said, 'Oh, I guess you've got a shortage of pharmacists.' 'No, we've got pharmacists coming out our ears.' 'Why?' and they said, 'Well, Charles Sturt University has a campus here and it's got the pharmacy school here.' Then they said, 'It's not going to last because they're about to move the pharmacy school to Bathurst' - well, Orange actually it might've been - and we expect that, you know, the numbers of staff will be dropping off.

But if you get people doing their training in the bush, a lot of them stay because, yes, you said, they make relationships, they, you know, learn actually it's really nice.

MR WHITE: Well, this is the thing about if you live in the city, you've got to spend two hours on the train going to work.

PROF KING: Yes.

MR WHITE: And I talk to a lot of people who've moved out here and they love it because they can get to work in eight minutes or they can walk in 15 minutes, you know, to work. But what people saying about getting them out here, for probably the last 15 or 20 years, M LC, Methodists Ladies College from out at Burwood, they've been bringing their girls out here. Right? They bring them out here and, like, they're 14, 15 years of age. They bring them out here and give them the taste of Broken Hill and I encourage them, when they come to our church on the Sunday, 'Thank you.' We get 30 or 40 girls.

PROF KING: Yes.

MR WHITE: 'Thank you, we would love you to come out when you become qualified doctors, nurses (indistinct), whatever you' - - -

PROF KING: Come back.

MR WHITE: 'Come back please, and fill our positions out here,' and I encourage these girls and they love it out here. You know, they stay out at (indistinct) where they wake up in the morning and there's four or five kangaroos at the door, you know, and they go, 'This is great out here.'

PROF KING: Yes.

MR WHITE: But we need to do this. I do an exercise class for the Wednesday morning which is operated by the Uniting and the young lady who does the class quite often turns up with a couple of extra girls who are actually out here for their training (indistinct) and they love it. They come out here and the go, 'Yes, we're fully qualified,' then they come back out like (indistinct).

MR GOUGH: Sorry; it's Peter. The problem with that is it's only six weeks.

MR WHITE: Yes.

MR GOUGH: So they don't immerse themselves.

MR WHITE: Yes.

MR GOUGH: It's good, but they don't live here and they might see clients once or twice and then (indistinct).

MR WHITE: Yes, that's right. But we need to have the, like I said, out here for the first two years. If it could be made so that they do this for the first two years of their training as part of their training. You know, and like you said, they'd make connections and I mean we had the guy who started Lifeline here moved here - Brian Nichols - moved here over 40 years ago and loved it that much here he moved. Admittedly he moved from Port Lincoln and didn't move from the city, but he moved out here and he could see that Lifeline was needed here, so went off to Sydney, and then he went overseas. He went over to New York or somewhere over there and it was - - -

PROF KING: Yes.

MS LATHAM: So I was a nursing student from Byron Bay (indistinct).

PROF KING: Sorry, can I get your name for the - - -

MS LATHAM: Vanessa; from RFDS. And so in 2009 I came out here as a university nursing student for five or six weeks through the Yooyah H Program and partnership with Southern Cross Uni. So that's sort of how I ended up back out here. So I've been here for eight years now and I'll probably stay forever. I don't want to leave; and I suppose I just had some other comment back on the mental health workforce with nursing, psychology, social work, counsellor. Like, while we all do different under grad discipline training or not even tertiary training, we all actually go off and do the same CBT Apt, DVT, complex trauma, PTSD, we do the same (indistinct) so that multidisciplinary team can actually provide a lot of the same services.

So I've been an advocate as a mental health nurse for Prudential Mental Health nurses and counsellors to either gathering work over the GP (indistinct) Care Plan or maybe as more directed towards some sort of block funding or something with the GP practices. But every GP practice should have some rural (indistinct) or mental health professionals.

Sometimes too with some of the psychology services, I've got staff in Dubbo, Cobar and Broken Hill and outreach. The psychology services we refer to, because they only have the limited sessions, they actually can't really delve into a lot of the trauma (indistinct) we need those block funding thing might be good that doesn't have a session limit and I have (indistinct) funded under (indistinct) which is that GP mental health nursing program, so it's through the PHN funding now. There's not much of it left though, that model, but it's got no session limits, so that's quite good.

And the only other point I just wanted to make which is sort of going back actually to technology, but it's the infrastructure. Like, we get a lot of different funding and if you go looking for it, there's a lot out there. But none of it generally is for buildings or infrastructure. So we don't have - just think of Telehealth. We've got 10 people in a tiny room. If you're on the phone to a client and then your colleagues are also on the phone and it's horrible. Like, we just get up and, you know, you just end up standing up somewhere in the car park or something and talking.

PROF KING: Yes.

MS LATHAM: I just think that's another thing, it's just a big point. There's a lot of funding for the service or the workforce, but you've got to have the buildings and the infrastructure as well as the transport logistics.

PROF KING: Yes, one of the things we had to do and I know (indistinct) is exactly that. The funding which you get for services doesn't actually cover the capital. So is that general experience?

MS LATHAM: Yes.

MS CROSSING: Can I just say something? It's Kayleen.

PROF KING: Yes.

MS CROSSING: So I've just recently started my job, a week into it, and we're still trying to find a social worker that, due to our funding, we've got lots of money sitting there but we can't use it because we'd need a social worker that needs to be qualified, you need this. We've probably had 10 to 15 applicants apply that, because they haven't got that degree. They've had (indistinct) 10, 20 years' experience living in Broken Hill, working in the community field, and because they haven't got that degree we can't - we've tried ringing up the funding body, 'Look, this is what we've got,' 'No, that's not good enough - that's not good enough.' Even though we've got a community person that's living in Broken Hill, that can't apply, they've applied and had to be declined.

PROF KING: So is that because it's written in the funding agreement for the relevant services that it has to be a social worker.

MS CROSSING: Yes, it has to be a social worker and we're trying. Like, the manager has been on the phone to the funding saying, 'Look, this is good getting all these applicants,' but because they've got - like, I'm diploma trained doing a degree. I was lucky enough (indistinct)

word) I've got a Diploma in Counselling so that qualified that funding to go to me. But that social worker - like, I'm working alone at the moment without any help from another worker because to get a qualified social worker that wants to come to Broken Hill or are already in - most social workers have got jobs in Broken Hill and that leaves some (indistinct) Yes, so as I said, I think there's been about 10 to 15 applicants we've had to decline or can't interview because they haven't got that degree.

PROF KING: Yes, so the funding is restricting, so it's basically input-based funding rather than outcome-based funding.

MS CROSSING: Like, we've got people that are 20 years' experience living in Broken Hill in the community field and we can't employ them.

PROF KING: I mean the gold standard for any services is outcome-based funding which, if you could do it - yes, you wouldn't say, well, you've got to have a social worker or you've got to have a psychologist or you've got to have a counsellor because you'd be measuring the outcomes.

MR GOUGH: Sorry, it's Peter. I think part of that is that organisations are risk adverse to people who are members of professional bodies (indistinct words).

PROF KING: They have a bit of paper, yes.

MR GOUGH: Yes, and they're very risk adverse to that.

MS McMANUS: And don't have something (indistinct) working ongoing.

MR GOUGH: Yes.

DR NACHIAPPAN: Ramu Nachiappan. It's a regulatory environment that Australia has become very good at. We're overregulated, but we're one of the most regulated countries in the world where a lot of organisations are top heavy administrative and the clinical services are just getting drier and drier and drier, and Broken Hill's the perfect example of that and where there is infrastructure, they are large structures, but the administration is such a big machination that the service provision disappears in that conglomerate.

Now, more graduates was supposed to mean more doctors and it hasn't happened. So there's been a tsunami of medical graduates in Australia from the days I went through (indistinct) Uni. I'm an 89 graduate, so I'm celebrating 30 years next week as a doctor.

PROF KING: Congratulations.

DR NACHIAPPAN: Thank you. So sorry I'm having to show off, and I've been here almost 30 years. So it is a grow of love for the environment. So more graduates doesn't mean more doctors. More graduates means more doctors queuing up in Sydney and Melbourne, Brisbane and Perth.

But doctors who are bonded, that's another experiment the government tried and failed miserably at because the bonded doctor has said, 'Oh, my girlfriend has gone to a different town. I won't go to the bush,' or, 'My dog's ill and I can't bring it to Broken Hill. There's not a good enough vet there.' All that type of stuff, so the bonding failed miserably.

So training in the bush; I agree. I had a medical student - and as Les pointed out, the MLC girls - she was out here 10 years ago and had such a good time as a MLC Year 10 student, she's come back as a final year medical student, spent a month with me here in the practice and (indistinct) university. So it does work but you see very few of them that do trickle through. It does work to a degree, but training in the bush is the key.

For example in Dubbo and the Monash Rural Medical School, the entire medical school training is in the bush. You can't just send them out for six weeks or 12 weeks. It's not enough. What Peter talked about; emersion. It's not enough and there's every year or two or three (indistinct)

PROF KING: Sorry?

MS COLE: Jo-Anne. I'd like to say Australia signed up as a - the government has signed up for international conventions on human rights and Indigenous rights. I think it's good to see so many kind hearted people and hard workers and the amount of people. But I think some people do have (indistinct) to care and I think, given our history and the social context, it's good that we have health and mental health as some sort of antidote, but I can't help but thinking a bit ironically about the social context that we all operate in and some of us are more well-mentally health speaking than others.

I'm a mental health system user. I had a friend who passed in the mental health system in Adelaide and hearing voices and then, was taken to the Broken Hill Hospital and sectioned - detained under the Mental Health Act.

PROF KING: Yes, compulsorily detained, yes.

MS COLE: And that was scary because I thought, well, (indistinct) start the symptoms were I thought (indistinct) human rights and Indigenous rights (indistinct) and just evidently my friend had passed after being in the mental health system in Adelaide and I was scared of getting sent back there and whatever.

PROF KING: Yes.

MS COLE: But also as a social construct, New South Wales and Broken Hill, to me as an Atjinuri woman, an Aboriginal from the Coorong in South Australia, sometimes what makes me laugh is this. New South Wales government would send me - when I was a very young girl - would send me a benefit with free transport in New South Wales and my homelands and waters are in South Australia and I'm like, okay, if I was well enough to travel and, you know, see my loved ones and, you know, have a natter and say, 'What's going on here?' it was a bit ironic that was the irony and I can - and before I got unwell I was studying a bit of politics and my BA and I had whatever. I didn't have my HSC, so I didn't have that background, but it's very interesting and I think everyone in Australia deserves human rights and Indigenous rights

and it makes me sad that I see, especially with people of mental illness, suffering in some way in those areas.

PROF KING: Thank you.

MR JONES: Just to follow up; it's happening even in the drought now, it's everywhere. Only when certain characters or, you know, how we identify people, farmers or whatever, we have (indistinct) professional ethics (indistinct) to drop or rise. You know what I mean? The standards of whoever walks through that door. What was your name again, sweetheart?

MS COLE: Jo-Anne Coles.

MR JONES: What Jo-Anne was saying - - -

MS COLE: Maxine Cole's daughter; you might know her.

MR JONES: I think we've got to sort of at professionals, stop that behaviour of leaving this mess that, you know, farmers (indistinct) so they must be doing all right. You know? Aboriginal people get that. You know? Their (indistinct) you know and we've got to have professional people are worthy - the human content - the human (indistinct) that go on and saying why couldn't they just see that person, you know, or their family, whatever.

MS COLE: Yes.

MR JONES: Not carry that all label them as a certain category of people or whatever, you know, or whether they live (indistinct) where they live down in wherever, you know. We have to stop that in professional people and that's - - -

MS HAYMAN: Well, that's what we're supposed to be doing. We're not supposed to - - -

MR JONES: Well, they don't matter. Look, the ethics have dropped. I know and so do people who go in with a tablet, there's another group (indistinct) head scan, you know, on a head injury. So we've got to work out better ways as individuals, let alone professionals, how we do that better, you know, and labelling people just on their parents or their culture or their location where they live, all these professions you know.

PROF KING: So that's a nice Segway into the broader - should I call it stigma or discrimination because I was using the term stigma, and someone said to me, 'Look, let's just call it discrimination because that's what it is,' and it seems to exist right across the mental health sector. So we know just from the status that if you've got a mental illness you may have physical illness as well. But your treatment of your physical illness will be different because of the mental illness. So in other words there's parts of the medical profession who say, 'Well, you're mentally ill, therefore, that's the cause of everything.' So I'm just (indistinct)

We know that there are institutionalised approaches that people (indistinct) stigma and discrimination. So for example if you've ever seen a counsellor or a psychologist try and get

income protection insurance and you'll find you can't. They just simply rule you out. It doesn't matter what you saw, whether it was 20 years ago, you get labelled for life.

You know, if you broke your leg, that wouldn't happen so why does it happen for mental ill-health. You mentioned sectioning.

MS COLE: We are very (indistinct).

PROF KING: And again, that's - I have some problems with this. Julie's not here. Julie's one of the other commissioners who is a lawyer and so we've had a few discussions about this, because I see that as just simply discriminatory because, unless you are a danger to someone else, you know, if you have a (indistinct) illness and you say, 'No, I'm not taking my medicine.' Let's say you're diagnosed with cancer and you say, 'Well, I don't believe in traditional medicine. I'm going to have an alternative medicine,' and the doctor says, 'No, no, that's going to kill you,' or your GP says, 'That's going to kill you,' and you say, 'No, I want to do this.' Well, nobody in physical health then says, 'Oh, well, we're going to stop you from doing that to protect yourself or your reputation,' or the other ways they can section you. I mean (indistinct).

MS McMANUS: But unless that's if you're of sound mind. So I guess if you had dementia and you were making poor choices about your treatment, then someone would override that as a duty of care. So I guess the Mental Health Act is to protect people who aren't of sound mind at that time who are making poor decisions who - - -

PROF KING: For themselves.

MS McMANUS: For themselves; who, when they're in a better state of mind, would not have made that decision and so, we're protecting people to get to that point where they're able to make better decision about their care and treatment, so it's very short-term.

I personally wish that the act could extend to drug and alcohol and I know it's something we haven't got; we won't fix in seven minutes, but we haven't talked about drug and alcohol today and it's - - -

PROF KING: Well, we can go more than seven minutes.

MS McMANUS: Okay.

PROF KING: Sorry.

MS McMANUS: Yes, and I think that the Mental Health Act does very well in the short-term management of people with mental illness and who are mentally disordered. I mostly have family members come to me asking the opposite; 'My mother needs to be in hospital; my sister needs to be in hospital,' and we say, 'The Mental Health Act can't be used for that. I'm sorry, we can't do that to help.' But I think with drug and alcohol, the system so poorly supports people who are intoxicated or have an addiction, who aren't in a position to be able to good decisions for themselves and I don't think that the current act - not the inebriate act - the

(indistinct) Act which is what it's called - doesn't serve the community and I think that we know that a lot of suicides occur - have (indistinct) more with drug and alcohol use.

So I guess that's one issue, as drug and alcohol in Broken Hill is an issue and I don't think that the mental health system protects people who are addicted or are disordered with drug and alcohol use.

PROF KING:

MS McMANUS: I'm going off track I know but - - -

PROF KING: No, and if people want to bring it back to broader issues of stigma, I'm very happy to but, yes, thank you for bringing that up because that is one I think we haven't touched on. So drug and alcohol comorbidities; what do we need to think about; what do we need to understand in regards to that in Broken Hill? To what degree is that a factor in suicide? If it is a factor in suicide, how do we deal with that problem?

MR GOUGH: Peter. We've had four suicides this week.

PROF KING: Yes.

MR GOUGH: I believe it's all male. That sort of rolls off the tongue a little bit for me and I don't think people really understand the gravity. It's a bit like the war dead; 1000, 2000, we lose the gravity, and it's four communities. That we would've had more representatives here that do have (indistinct).

The stigma - I deal a lot - across the board, but I've fallen into the men's' mental health - and these are all men. They're middle-aged men, typically coming from a very, very volatile abusive childhood where they've been either sexually or physically abused for a lot of their time. They get to the point where they drink too much, as we all know, and we're talking about significant amounts; four litres of wine plus a day.

Where I used to work up in the north coast, they used to inject methylated spirits, abhorrent ways to get anything into their system to make the trauma leave them and I think that the - and we spoke earlier about - I think the actual solutions are quite easy, but they're missing the mark.

PROF KING: Yes, do you want to expand?

MR GOUGH: And it's stigma; because real men don't cry. Now, we've heard that for a long time, but not to diffuse from other charities and things like the Pink Ribbon Foundation, Women's breast cancer, one of the organisations, and there's a (indistinct) breast care nurse in every town funded by the McGrath Foundation. Who's helping the blokes? We've got Beyond Blue with some ads, and that's great, but they're just ads.

Where is the funding out here for Beyond Blue? Who's going to fund Maari Ma or the Far West Local Health Service to just run men's programs and focus on trauma. Suicides come from trauma; they don't come from alcohol.

MS COLE: You know, they've got other Australians like the Stolen Generations. Like you can't get away from your history. It's (indistinct).

MR GOUGH: So we've got the Feeling program with Maari Ma which is focused on that conversation which is one of them. However, who's controlling and managing the trauma? Now, we all touch on it but disengage and all that but it's all because of stigma because men don't want to talk about sexual assault. You know, men don't want to talk about their fathers or their mothers or their mother's body or their father's or the deaths or the abandonment because it's too hard.

So it's probably, as all the clinicians know, it is the hardest of all psychological conditions to treat because there is no tablet. We have to get people relive their experiences to treat their experiences and, when we do that, people disengage because it's too grotesque for them (indistinct). So we're all pretty good at dealing with the peripheral of that. But to get somebody that will leap forward and say, 'I'm fixed,' is folly. It's not going to happen.

PROF KING: So how do we do that and it's not actually just an Indigenous but it is (indistinct words). recognise it in your own role. How do we - we've got a twin problem then of intergenerational trauma and stigma about things (indistinct) come before. How do we get around those twin problems?

MR GOUGH: It was interesting; because I spoke to a guy yesterday who was severely gang raped as a young male in one of the communities here and he's 40-odd.

PROF KING: Yes.

MR GOUGH: Now, wanting to lay charges, but he was suicidal two weeks ago. Now, the treatment wasn't actually treatment, it was counselling.

PROF KING: Yes.

MR GOUGH: It was sitting there, being there, believing and listening. True; we've all done some pretty serious training in this (indistinct) of stuff. But there's how many male counsellors in this room? No disrespect to the women, but blokes sometimes don't want to talk to women.

MS BEESTON: I agree.

PROF KING: Yes, and women sometimes want women counsellors.

MR GOUGH: And being a little bit grey haired and that sort of stuff. It's not a father figure, but it's a peer. So we've got lots for adolescence and kids; it's wonderful there is that sort of stuff, but who's talking to middle-aged men who are typically the ones killing themselves - typically.

DR NACHIAPPAN: A large majority of Australians visit their GP at least every year. So the general practice is recognised in Australia as perhaps the port of call for every Australian, before something like this happens. However, the way general practice is funded through Medicare, it doesn't allow the provision of services for the people who actually need

it. For example, in a bit like a 15-minute consult, it is not going to solve this issue.

PROF KING: So how do we create, maybe through a GP, but maybe the GP is the gateway into the effective services. How do we get the effective in community services? I mean, is it just a case that we just need - it is just a workforce issue, but until we get a workforce in, we're just, in a sense, wasting our time. That has to be done (indistinct).

DR NACHIAPPAN: (Indistinct) to be honest.

PROF KING: Yes, okay.

MR GOUGH: Because everybody's trained here, but they're far too engaged with somebody with some significant trauma. It's not for a six session Medicare plan. It could be two years. It could be five years. I've dealt with people for three years, and then just as I'm saying, look, I can't help you here, bang, there it is. Now we'll get into it. So it's funding the workforce, and if we look around the room, where are the male Indigenous counsellors? Not just peer counsellors, but trauma counsellors to, I suppose, take these people back from the brink.

Listen to them and say (indistinct) contracts and suicide contracts and things like that. Keep them alive. Because the longer they're alive, the more chance that they will stay alive.

PROF KING: Alive; yep.

MR GOUGH: Because I'm really - after many years in the police force, I've cut a lot of people down out of trees. We forget that each one of those people that dies is so valuable, and four in two weeks. And seriously, my people that I work with are expecting six more in the next two weeks.

PROF KING: How do we - - -

MR GOUGH: Which is horrific. It's proactive. We know it's going to happen, and we're just bracing for it to happen.

PROF KING: Would that also work with kids? So my background is - for various reasons, so for six years I was going back and forth between Melbourne and Perth, and so when the Kimberley cluster of deaths, the 12 plus one occurred, sort of a bit eye-opening for me. The Coroner's report there makes it very clear that these kids did not interact essentially with anyone, certainly no health services, before taking their own lives, and that was a terrible cluster. Male counselling. How do we help the kids?

MS BEESTON: Yes. Just a small point on that. I've been working in a high school in that counselling role, I probably dealt - and I'm talking only part-time and probably only over, like, a couple of years. I saw at least three or four children that had talked about suicide to someone, and they ended up in front of me.

PROF KING: Yes.

MS BEESTON: So, yes, I'm just saying that kids will open up to - to people. They have,

again, that connection with, that relationship with. Whether it's a teacher, whether it's a youth worker.

PROF KING: So it's only the schools - so GPs are fine for adults, but is it the school for kids that we should submit to parliament.

MS BEESTON: Look, I just think they've - - -

PROF KING: As the entry one, just casually.

MS BEESTON: Yes, I think, you know, certainly, you know, they come to us in the school when they're (indistinct) just someone that can help them further.

DR NACHIAPPAN: My feeling is to throw some light on that. I run a private practice. It's a (indistinct) practice. So the clientele I attract obviously exclude a lot of very vulnerable people. Teenagers are rarely seen because of that one-day a week now, I work for headspace, it's a better cost. Because I was losing the skills in managing cross-sections of society, because I don't get to see them. Now, generally speaking, people will take their pets to the vet, but their children to the doctor; maybe very young children, but the teenagers, we're not engaging with the teenage population. That's a big hole, I think, in society.

MS HAYMAN: It's Jane. But in saying that, kids, especially teenagers, are reluctant to talk to us as well.

DR NACHIAPPAN: There's that as well. Yes, that's true.

MS HAYMAN: Exactly.

DR NACHIAPPAN: It's a two-sided thing, so I don't want to take all the blame. It's two-sided. It's not just general practice or service providers. It's also the consumer. So how do we engage the people who need to be engaged? I think that's one of the biggest issues now in mental health in Australia. The people who need help are not seeking help. So ones who don't really need help, you know, your mild anxiety, depression. Nothing against that, but they're not on medications.

They're very good at coming to the GP asking for mental health plans, getting their six visits and four follow up visits. They're soaking up the funding that's being put out there. But the target population, we still don't know who they are. In fact, we only find that once they've suicided.

(Indistinct)

MR GOUGH: I've got one point and then I'll probably have to go, which is good so everyone else can get a turn. Where are the Indigenous counsellors? This local population is so rich and its emotional intelligence and connectivity with everybody. They're full of intelligence to do these courses, and we've got a great program there for Indigenous health workers. We need Indigenous psychologists, counsellors, OTs, everybody. But where do they train? It's very expensive to move to Wagga or Dubbo or Mildura training. But where do they train to do these

higher level, specific trauma, suicide prevention courses?

And that's probably where my solution, I think, is simple but hard, is it is funding and it is staffing. Because if you've got somebody that can relate to these kids, not an old bloke like me, but a young, you know, a really good young person in that school environment, they're going to have footy with them, they're going to have cricket with them. They're going to develop this rapport that will continue outside the school, and probably for the longevity of their teenager years, which gives them a go to.

MS McMANUS: I think the Aboriginal traineeship program at the mental (indistinct) and alcohol service is 50 per cent effective in retaining our staff who go onto become clinicians on our service, so Aboriginal clinicians. But again, and we keep talking about it, it's having the experienced staff around to support the training and supervision of those staff. So we've taken on a new - we get lots of applications for these positions, by the way, more than any other physician.

We've advertised for a psychologist three or four times; we've got nothing. But we advertised the Aboriginal traineeship and I think we got 12 applicants. So, the last round of the two positions (indistinct). But yes, it's about having the experienced staff around to support that program.

PROF KING: To be able to support the (indistinct).

MS McMANUS: And so next year, I think our community team couldn't support another trainee.

PROF KING: Now, we had a comment from the back end there.

MS PICKETT: So, I agree with Peter. It does actually come down to funding and money. Like, at the moment, the school counsellors, there's not even one school counsellor in every school now, where here a few years ago, there was. We're struggling to get counsellors out into the schools. So I think you need to look at why. Like, where's that attraction. Like, where's the packaging, and stuff like that. So then that puts stress on the services, so hence they probably (indistinct), because the schools can't support, yet we're meant to be funded for it. (Indistinct). Anyway, a men's counsellor.

PROF KING: Sorry, just before we go off that, also. So you had 11 applicants for two positions for Indigenous counsellors?

MS McMANUS: Yes.

PROF KING: Yes, wouldn't it be great if you actually had funding so you could - and the ability to support them.

MS McMANUS: To support them.

PROF KING: Train them, so you could say, yes, come on and explore a little.

MS McMANUS: Absolutely. The interest is there.

PROF KING: Yes, okay. Sorry.

MS PICKETT: You know, we've actually - we had - like, we get students come out to do placement at Lifeline and some of them are absolutely fantastic, but we can't retain them, because we don't have the funding to pick them up.

PROF KING: Yes.

MS PICKETT: We had a youth counsellor last year. Amazing. No, headspace in Adelaide have now got her because we weren't (indistinct) funding. Yes. At the moment, we've got an Indigenous student with us, haven't we? And she's fantastic, but there's no way she's going to stick around either. Yes, so it is. I hate to say it's about the money.

PROF KING: But it is about the money.

MS PICKETT: But it is about the money.

PROF KING: Yes.

MS PICKETT: Yes, and it is also about how - how we spend it. You know, you might get - we only get dribs and drabs of funding, but there's so many restrictions about how we'll do it. So, you know, it can't be vehicles or anything like that. We do a lot of outreach, so, but you know, you've got to have some way to get there.

MS SANDERSON: So can get a message through to whoever gives the funding that they should (indistinct). They should be giving it to Lifeline, when their core business is suicide prevention.

MS PICKETT: Yes. Like, Maxine's one of our counsellors. How long have you been a counsellor there? She was on the (indistinct) beforehand.

MS MAXINE: Ten years.

MS PICKETT: Ten years, and so the funding for Maxine - so she's on a casual basis, and it's just like a call in basis, but we get that through FACS.

PROF KING: Yes.

MS PICKETT: Which isn't enough.

PROF KING: Yes. The one that really resonates with me is you had 11 applications - no, no, sorry, this is - previously - in a previous life, I had this discussion all the time with the powers that be is that I would overemploy. I'd say, 'You don't have to worry. I'm in charge of the budget, you know, so yes, we only get two spaces available. Completely different sector. But I tell you what, we had five great applicants. I'm going to employ all five of them. But don't worry, because I'll still meet the budget.'

And if you get the right people in, you actually end up finding that they're savings elsewhere and, yes, it's unfortunate but we've got a system that is very much – we've got to fill the gap.

We've only got that position, we can only fill that position.

MS McMANUS: I should clarify that they were traineeship programs.

PROF KING: Yes, yes, no, I understand.

MS SMITH: I think – Vanessa, I think that's a really important thing is it's because it's the type of program that it is. So someone just has to have a passionate interest in pursuing that and they were actually afforded an opportunity to have the Bachelor's Degree at the end of three years. And three years of workplace training in the process.

So if we – I think - it's possibly a model that we could be looking at with other disciplines as well where people can actually be financially supported while they're doing their degree.

MS McMANUS: They can.

MS SMITH: And then, over three – they're more likely to stay back in that community, plus you're actually getting people who have – are born and bred in the community, who want to stay in the community and for any – you know, for other reasons would choose not to go to a capital city for training; they'll actually stay and be trained with (indistinct).

PROF KING: Des, and then I'm just going to very quickly ask if there's any huge issues that we've missed because otherwise we're not going to have time, so.

MR JONES: I was going to – just before Peter was going to leave, just a question. Do you think that this is the first time you've all seen the same room or? That's probably half the problem now.

MS PICKETT: We have great relationships.

MS McMANUS: Yes.

MS PICKETT: Where we have catch-ups once a month.

MR JONES: Right.

MS PICKETT: So that's health and RFDS and Lifeline, we're always having regular catch-ups and we welcome anyone that wants to join our - - -

MS McMANUS: And Mission Australia, I think, as well. And I know that health and (indistinct) have been building their relationships in (indistinct). So – but like, it was just said in our lunchbreak that we used to have our mental health interagency meeting and that stopped. But that's when we all used to come together in one room and talk about our services, and that hasn't happened for a while.

MS SANDERSON: Could I just say, Joanie, can I just say something on a lighter note? When we were talking about engaging teenagers, I find the best way that I engage with them is I take them out to Bells for a milkshake or a spider and we sit in the little side part and they just start talking. And I find that we've got a famous milk bar here, Bells, and it's at the South and kids love going there for a spider or a milkshake. And they just start (indistinct) and just start talking. So you just make that connection over, you know, over a cold drink and yes, so it's a good, yes. You know, that's what I find really helps me with young people.

MR WHITE: A cup of tea or coffee does the same thing.

MS SANDERSON: Well, I don't know if they'd be interested in that.

MR WHITE: I know, but that's with the adults.

MS SANDERSON: Yes.

MR WHITE: I mean, I visit quite often. My Sunday afternoons are taken up visiting – visiting. So I'll just pop in and see people that I know that either have been to church or have missed that day. And the first thing they ask is 'Would you like a cup of tea or coffee.' And I can understand why Ministers and people who do a lot of visiting put on a bit of weight, because the person they want to deal with, through a cup of tea or a cup of coffee.

PROF KING: Caffeine used to sort it out, too.

MR WHITE: Well, I can't have caffeine, so I've can't have coffee. But, well, neither tea or coffee. But yes, that's that thing. It's sitting down. And I've got to the stage now where even if I don't really need a cuppa, I have one because they – that's a good sharing time. Nothing like sitting around and having a meal with somebody to really share. And that's what saving lives is about, isn't it? Sharing.

MS OSMAN: And what is – sorry. Emma. This isn't in our capacity. It's as a community member. And it's touching on what Ramu said, identifying and how to access individuals in the community that don't even actually know they need to or want to access the service. And it's also touching on what Des said about supporting families and giving families tools to support people before they get to that acute stage.

It's just an observation about a family within the community that identified in someone that there's a big problem. They're reaching out. They need help. They need this person to have help. The person doesn't want help but the family's saying, 'What do I do? Do I just sit back until he breaks the law and the police detain him? Where do we go with this?' And so, you know, we may not be able to – what do we do in supporting those families? Because I think there is a lot of families in Broken Hill that are perhaps experiencing that. And it's – as I said, it's not – I don't know what the answer is. It's just an observation that is part of that link, is – is, yes, that family unit.

MS McMANUS: And it's, look, you're looking at those – it's not an early intervention because this person's identified, but it's – some services sort of say, 'Well, look, they've got

to come in. They've got to ask for help.' But you know, where Joanie's talking about and Peter's talking about having a male that might go out and just build a relationship and not try and do anything else, but just build that relationship.

MR GOUGH: Can I just add – sorry - to Emma's points. Sorry, it's Peter. I thought I was going to shut up. Not long after I got here, I got pulled into the police station because an Indigenous guy who was high on Ice did a car-jack. And they just needed somebody to (indistinct) with his things. And his sister was there, middle 30's and she was just so happy because he's now going to gaol and he can now get off the Ice and the grog.

PROF KING: Hopefully.

MR GOUGH: In gaol, yes. So gaol out here for Indigenous men is viewed as a good thing.

DR NACHIAPPAN: A therapeutic stage.

MS PICKETT: I've probably not heard that before.

MR GOUGH: It's a therapeutic time where they get fed, dental, all of that sort of stuff. I don't know what Des's experience will be on that? I'd love to hear it.

PROF KING: I'd love to hear it as well.

MR GOUGH: I don't know if Des would share that? But certainly the males that I see here, life's getting too hard, so I'll just drive in front of the police station, beep the horn and I'll go to gaol for not having a license. And that – I thought that was a bit of a myth, even when I was a policeman. But it is so not. For every (indistinct) so, I'm doing (indistinct) so I just need to go back to gaol for a while.

DR NACHIAPPAN: It is very true in this community. I was the sole provider with medical services at the local gaol almost three years. Many, unfortunately, Aboriginal males see that as their health farm, if you like. To be incarcerated. And to go back in again for incarceration to improve their health. Now, that's really a terrible state of affairs.

Especially for (indistinct) , isn't it. But that's known, that's the truth in Broken Hill.

MS SMITH: So that's really a crime, yes.

DR NACHIAPPAN: So that's very much exactly what happens. They come in, they say, 'I've lost my glasses.' 'Get my eyes tested.' 'Get my teeth fixed.' And 'Doctor, is my blood pressure going all right?' 'Should I go and see a specialist?' And I say, 'Why didn't you do this when you were outside?' And they say, 'I haven't got time for that.' Break in – break into too many cars or just – just doing that, just living their lives. And it's a terrible state of affairs that people have to commit a crime and incarcerate themselves in order to improve their health including their mental health.

PROF KING: Well, hang on, so – okay. So that's where I want to jump in. When you say improving their mental health, so the services, the mental health services in the prisons at least

the ones we're aware of but I'm not aware of what the local prison here. But the ones that we've looked at, the mental health services are pretty much non-existent.

DR NACHIAPPAN: Average.

PROF KING: Well, prisoners aren't allowed to claim the standard Medicare type of approaches so I'll give you a simple example. So – and, what about this one, another area I've looked at: Bandyup Women's Prison, which is over in Western Australia and ridiculously overcrowded, so when we were looking at it, it was approximately, I think it was built for something like 300 women. It had close to 600. So they just double-bedded every cell which led to problems in the cells. So massively overcrowded.

Their only mental health services were a psychiatrist for half a day every fortnight. So completely inadequate for the population. The prison superintendent estimated it was somewhere around two-thirds of the women in that prison had mental health issues. So whilst hearing that, yes, so for some people they see gaol as, in a sense, an alternative to being in the community which is a terrible thing. I also can't imagine – I can only imagine that they get worse by being in prison and that may just reflect my background in the prisons that I'm aware of.

So I think I want to make sure that I'm not bringing up my bias to –

MR GOUGH: I don't think it's for mental health.

PROF KING: No, okay.

MR GOUGH: They're going there for – because we're talking about some communities where we are talking third world abject poverty here, so they're getting fed, they're getting their clothes washed. That's what they're going there for because it – and a lot of their unfortunate relatives are in there. So it's like a – not a catch-up, but they're safe there. They're protected there.

MR JONES: Yes. And they don't need to think about what they do, do they.

MR GOUGH: It's - as Dr Brown said, it's a safe place. It's not about mental health. It's about – it's actually, and that's probably – we're running out of time - but it's about detox. It's about rehabilitation.

MS McMANUS: Yes, it's a (indistinct) state of also stopping drug and alcohol use for three months.

MR GOUGH: Yes. And they know that, 'I've got to get off so I'll go to gaol.'

MR JONES: No, even then, we've got to be careful we don't accept that as a - - -

MR GOUGH: Yes.

PROF KING: Yes.

MR JONES: - - - that we don't accept that as a pathway, because the majority that I speak to, like, they really - they don't want to go to gaol. Right? The courts just - the court system deals - that's the hand they're dealt through the court system based on whatever happens.

And I think Stephen, it's about - they get some respite in there, sadly. But it's when they're released, they don't get the follow up from when they're released back into the - in the population, back into the community again. So that's where we need to pick up, you know?

PROF KING: So let me follow up on that. So let's say it is drug and alcohol and they've gone with it, yes, okay, so they've gone dry which means that you have better protections in prison here - - -

MR JONES: Well, you don't - a lot of people are going to gaol, too. I mean, there's one a week that dies in gaol, you know?

MR GOUGH: The WA Prisons had a real drug problem in the prisons when we investigated them. I mean, it was - - -

MR JONES: They (indistinct) go, so let's - let's be careful and make it a safe place because a lot of people do die in gaol. We don't hear about it because it's all via a cop house where you've confidential information for the families. But I need some follow on stuff.

I mean, you know, medicinals are a restraining process that goes on as well, you know? Here they just give them tablets to quiet them down and that's it, so. So we need to be careful of how we look at all that, you know, that incarceration-type - you know, well, some people call it respite or whatever - but it's not. It's actually - I wouldn't like to be locked up with anyone.

PROF KING: No.

MR JONES: With a bunch of murderers and criminals and fearing for your life. But so we need to be mindful that when they come out though, it's - and when they're needing the support and the engagement again, to - - -

PROF KING: So the problem is there's no one to do that?

MR JONES: No.

PROF KING: Yes, I was about to ask. So there is no support at the moment for people coming out of there?

MR JONES: No, I mean, may the Lord save you, but if you're released out on the 21st, like tonight, 29th or the 28th, if you're released out on the 28th at 12.01 pm, you know, well, that's the end of the 28th.

PROF KING: Yes.

MR JONES: So you're released out in the darkness and if there's no one there to pick you up, you're on your own. So basically you (indistinct) later (indistinct) again, because you might - you might not have anywhere to stay. So all those things are going to deflate.

But I think, it's about – it's about – an eye to let that – the upfront stuff, you know, that – all the backend stuff, a lot of sense of design to deliver that, you know? After the fact, (indistinct) happened, well, everyone – but it's all preventable stuff we can do up front that I'd like to see.

You know, there's an investment in those proper non-committal approaches. And, look, right across Australia, we said we'd have a program called mini-development employment program. So that was sort of like Work for the Dole programs, you know, there – there was no employment. It kept a lot of people occupied, a lot of kids were going to school, people were valued, they got paid for what they'd done and there was some sort of contribution to the community. So when they closed that program, we saw all the spikes in domestic violence and what not.

PROF KING: Can I ask you why they closed that program?

MR JONES: Just a political decision based on Australia's community saying it doesn't work.

MS SANDERSON: Jeoff Hardy was in at the time.

MR GOUGH: No, it's lack of funding. It's like, I - - -

MR JONES: No, it actually was a million – a multi-billion dollar program. And they just closed it down over night.

MR GOUGH: (Indistinct) lack of funding for (indistinct).

PROF KING: So was it a lack of funding or was it a view that - - -

MR JONES: So it was a politically decision.

PROF KING: - - - it was a discriminatory program because to receive the relevant benefits, Indigenous Australians had to do different things to non-Indigenous Australians.

MS SANDERSON: No, because it was for the general community.

PROF KING: For the general community. Okay. Yes.

MR JONES: I mean anyone – anyone who's unemployed in our communities - - -

PROF KING: - - - was able to access it.

MR JONES: (Indistinct).

PROF KING: Okay. Just wanted to clarify that.

MS SANDERSON: Could I just share something? Up at Jamendi earlier this year, they had a music festival and the police and the Indigenous community worked together and during that evening there were a few things, where you could hear yelling and stuff. And as soon as that happened the police stood back and the Indigenous men just went around and got around this person and they just calmed them down.

Took them for a little walk and then brought them back in. And like, when you're talking about people coming out of gaol, that's what people need to do - gather around them. Because I – it was beautiful just watching this. Just seeing them just gather around, there was no raised voices and they were just, you know, helping them self-regulate by just being there with them. And that's what we need.

It's like there's all this stuff – it's easier to put somebody in gaol. But it's so much harder to actually have a program where you can actually walk alongside these people when they come out and then get them into, you know, perhaps Indigenous programs where they can be learning about their mental health and, you know, and if you're there just being there with them, they're more open to receive what people are trying to give them after.

But that was such an impactful night for me, just seeing that, you know? They were just – it was almost like this silent little brigade went in and just you know, put this safe haven around them.

PROF KING: Yes.

MS SANDERSON: And I think that's what we've got to do with people that are struggling with mental health. You know, it's like just making sure that there are programs there that you can just, yeah.

MS McMANUS: And I think the whole music festival in itself is a whole other example of lifting the community spirits.

MS SANDERSON: Yes, it was beautiful. Yes.

MS McMANUS: And another early intervention program that we don't always recognise the benefits on mental health in a community, just by having those sorts of events. But you're not going to get funded to run a music event.

MS SANDERSON: No, no.

MS McMANUS: But I do a lot of program.

MS SANDERSON: But I think it's – but because of the loss of the River and all that - - -

UNIDENTIFIED SPEAKER: (Indistinct words).

MS McMANUS: I've got some money that I could kind of (indistinct).

MS SANDERSON: But see, but again, that's so simple a solution, you know, it's like being - connecting with people. It's about that connection, and even if you're not, you know - - -

PROF KING: It's creating a sense of community and, yes.

MS SANDERSON: Yes, and it's – it's that connection that they feel when they come out that - - -

MS McMANUS: Sorry, we do have a community restorative centre, just and that's for supporting people who are released from prison to reintegrate. I don't know how long that that support lasts but it does exist.

MR JONES: In exchange that there's actually focus more on in prison now than out.

MS McMANUS: Okay.

MR JONES: And so which is a bit (indistinct).

MS LATHAM: We have – we have Caitlyn and a few other people who are mainly our drug and alcohol and communication therapists who sit in that building sometimes and (indistinct). But there's a group writing (indistinct) we have at the moment. And they meet people wherever they want really, around the town to (indistinct).

PROF KING: Okay. Just noting the time, are there any issues that we haven't touched on today that people really think we need to touch on that – remember this is the mental health inquiry. We have strayed a little bit past it, but you'll recognise pretty quickly that – yes?

MS HAYMAN: Yes, I think for younger men around twenties early thirties.

PROF KING: Yes.

MS HAYMAN: Neami run a program where they can actually go in and stay for a few weeks to get off the drugs and that. But they have no thing here that actually helps younger men with their mental health problem. I know a person, he obviously had a drug problem. But he also had extreme mental illness and he was, because of the drugs, he also had psychosis. Now, he couldn't stay at Neami until it was proved that he didn't have his drug problem. But he was released before they dealt with his mental health problem.

PROF KING: Okay.

MS HAYMAN: And he was in a really bad place for a very long time. There's – it's a big gap. You cannot get help for these younger men. Or these men in this age gap. The sort of - Headspace will deal with them only until they're 25, and after that they release them into the wild and they've got to look after themselves.

PROF KING: So the program is Neami, I think?

MS HAYMAN: Yes.

PROF KING: Yes, so it's a drug and alcohol program?

MS HAYMAN: Which is – it's a (indistinct) business.

MS LATHAM: It's a bit like an (indistinct) that manage a team bed sub-unit in - - -

PROF KING: Yes, we have them here.

MS LATHAM: So, yes, so – but they're actually – they're New South Wales help beds, and Neami run the program, (indistinct) can be placed in non-criminal's peer support. We added a (indistinct) support and health service, so it's a funded mental health program.

It has over time, taken people with drug and alcohol issues because they can have all those other mental health issues underlying that. But they need to be able to not be using substances while they're there, because it's not deemed that the program's suitable for them at that time. So I suppose that gets into what other services are available for people with drug and alcohol issues. And that's why we have services, which are pretty lacking.

MS HAYMAN: Yes, very lacking. And to follow up health. There was none once he left. And I think he was visited once by the team members that go out in the community and that was it and then he was just left to it. And no doubt he went downhill again really, really quickly. He just went back to his old ways, same mental health problems.

PROF KING: Okay. So the trouble – is the trouble the Neami drug program, then the intensive for a few weeks but then there isn't the supporting - - -

MS HAYMAN: Yes, yes.

PROF KING: Okay.

MS HAYMAN: There definitely needs to be something that fills that gap. Because these are probably also the younger men that are actually going out and killing themselves.

PROF KING: Yes.

MS HAYMAN: Because they've got (indistinct) or they don't feel like - stigma, once again they don't feel like they can go and visit a doctor or - yes, and they just seem to be lost. That's very lacking in this town.

MS PICKETT: So I think in that instance like there probably needs to be communication between services like, you know, is it possible for like, you know, Neami to contact us and say, you know, like a handover to another counsellor or something like that or - - -

MS HINTON: They do do that. There are times when they have a collaborative party which - as an exit, and I've actually participated in a couple of those.

MS PICKETT: So maybe that's just not happening enough.

MS McMANUS: Yes, it's got some peer positions and it's got, yes, but, you know, they are usually very good - - -

MS PICKETT: Yes.

MS McMANUS: - - - at talking with the consumer at discharge about what services the consumer might be interested in engaging with and sometimes that's - - -

MS SMITH: And (indistinct) engaging those services while they're (indistinct) so you've got that - - -

UNIDENTIFIED SPEAKERS: (Indistinct words).

MS McMANUS: (Indistinct words), has done.

MS HINTON: So when - Jan, again. When he left this service he was good, he was clean, his mental health was a lot better, and I guess they thought, okay, well you're good, you're leaving here in a positive way. Well that lasted for a few days until he went and seen his mate and - yes.

PROF KING: Yes and - which also, when we go back to a prison situation, we know that you're released from prison and you don't have the support services in the community, so who do you catch up with? Well you catch up with your mates, and guess what they're the guys who got you into trouble in the first place.

UNIDENTIFIED SPEAKER: Nothing has changed.

PROF KING: (Indistinct words), yes.

DR NACHIAPPAN: They've spiralled down (indistinct words).

PROF KING: Yes. Yes.

MR JONES: You don't have to come out of prison to get that, it can happen to anybody, you know?

PROF KING: That's true, yes.

MR JONES: You don't know what trigger will trigger somebody that you thinks all doing well (indistinct words), you know? It's happened.

PROF KING: Other big issues?

MS OSMAN: I want to just touch on drought and drought mental funding.

PROF KING: Yes. Yes.

MS OSMAN: At the moment - I can't comment on the funding that's available at the moment but from my perspective, you know, the health (indistinct) got new drought funding. It seems as services - yes, honestly I can't comment on that, I only comment as a consumer previously just within a service is that - and as a consumer if it doesn't rain (indistinct words) money and a quick fix deal then the business relationships and dynamics. So that's just my observation is to know that drought funding for mental health is a very - it's a long term fix, even once the drought has broken. The impact that this period of time has on business, on family dynamics on individuals is something that's going to need funding and programs in the long term.

So I just want that noted as an observation because I know that often when there is a crisis of some sort you get adequate funding but then the fall out that the fundings not there to build again after the incident. So it's just a notation.

PROF KING: All right. I'll draw it to a close at this stage.

MR JONES: Stephen, just one quick - - -

PROF KING: Please.

MR JONES: In the commissioning process of services, there's got to be a component where - whoever get the - whoever the successful tender is they must engage with the other services, you know?

PROF KING: Yes.

MR JONES: As part of that whole commissioning.

PROF KING: Yes, there has to be a way to coordinate.

MR JONES: Yes.

PROF KING: And services working together.

MR JONES: That's right.

PROF KING: Want to make sure that people - - -

MR JONES: If I'm going to receive money off a certain program I should be in that, I should be talking to who's relevant or - you know?

PROF KING: Yes.

MR JONES: As part of the contract, you know?

UNIDENTIFIED SPEAKER: Absolutely. It should be part of the (indistinct words).

MR JONES: It should, yes, it (indistinct words).

PROF KING: There also has to be funding for that because governments are very good at saying, well, we want you to do all these extra things but you're getting the same funding as before.

MR JONES: Yes.

PROF KING: And as you've said (indistinct words)

MR JONES: (Indistinct words), yes, that's it (indistinct words), yes, exactly.

PROF KING: Okay. Thank you very much. Thank you to everyone today. Thank you for those who have spoken to us. I've found that very helpful. Thank you for those who have also just joined us as observers. There are lots of muffins. Please feel free to take muffins, so - - -

UNIDENTIFIED SPEAKER: Well, I could take some back to feed the workers?

PROF KING: Please do. Yes, take a box. And formally I will adjourn until 9 o'clock on Monday 2 December.

**MATTER ADJOURNED UNTIL
MONDAY 2 DECEMBER 2019**



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

PROF STEPHEN KING, COMMISSIONER
PROF HARVEY WHITEFORD, ASSOCIATED COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

QUALITY HOTEL REGENT ROCKHAMPTON 192 BOLSOVER STREET
ROCKHAMPTON

ON MONDAY 2 DECEMBER 2019

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PROF KING: Good morning all, and welcome to the public hearings following the release of our draft report for Productivity Commission's Inquiry into Improving Mental Health in Australia. My name is Stephen King and I am a Commissioner in this Inquiry, and beside me is my fellow Commissioner, Harvey Whiteford.

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

The purpose of this round of hearings is to facilitate public scrutiny of the Commission's work and to receive comments and feedback on the draft report. This hearing in Rockhampton is one of many around Australia in all states and territories, in both capital cities and regional areas, and we will be working 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 automatically be 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 manner, but I would like to remind participants that there are clear structures in our legislation for how these hearings are legally backed.

A full transcript is being taken. For this reason, comments from the floor cannot be taken. The transcript today will be made available to participants and will be available from the Commission's website following the hearings. Submission 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 not 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 and use the space by the coffee and tea area. If at any time you feel distressed, please approach one of our staff, who will assist you.

In the unlikely event of an emergency requiring evacuation of this building, the exits are located down the hall in which we came in, to the left and right, and upon the evacuation tone, please leave the building and assemble in the carpark, which is out to the side to the left of this room, if you are facing me, unless an alternative assembly location is notified by the fire wardens.

Our first participant today are going to be representatives from Queensland Alliance and Mental Health, and we will now ring them in. Hello Craig, Stephen King here. I'm here with Harvey Whiteford, and we've just started our hearings. You're okay to have a bit of a discussion at the moment?

MR STANLEY-JONES: Yes. Yes, that would be good. I was expecting you at ten past 9, but (indistinct).

PROF KING: No, no, we're just a little bit early. Very efficient.

MR STANLEY-JONES: No worries.

PROF KING: That's what happens when you're dealing with the Productivity Commission.

MR STANLEY-JONES: Great, thank you.

PROF KING: So formally, Craig, could I ask you to state your name, any body that you're - organisation that you're representing, and if you've got any opening comments that you'd like to make.

MR STANLEY-JONES: All right. My name's Craig Stanley-Jones and I'm a board member on the Queensland Alliance for Mental Health. In terms of opening comments, I appreciate the opportunity to present a point of view of Queensland Alliance and broadly of members here today.

PROF KING: Thank you. Can I run through a few issues? So, your initial submission focused, I think, really on four areas. So I'd like to run through those, and have you had a chance to have a bit of a look through our draft report and the recommendations there?

MR STANLEY-JONES: Yes.

PROF KING: Yes.

MR STANLEY-JONES: Yes, I have, and just wanted to provide some feedback (indistinct).

PROF KING: Yes, okay. So let's try and - happy to have your feedback as we're going through. So your initial submission, first focus was on rural, regional, and remote issues. Any comments that you want to make sort of following up now on our draft report, particularly on where we've dealt with rural issues.

MR STANLEY-JONES: Look, only in relation to - yes, to the need of people in rural and remote communities. I mean, there's probably no further comment in relation to what we've already submitted there in relation to rural and remote communities. I mean, needless to say that, you know, the NDIS more broadly is not - is not addressing the needs of people in rural and remote communities, and I know there's moves underway to address that. Yes, there seems to be a marked failure there in terms of the work being done in that space. But I think that's already been noted at different times there.

PROF KING: Okay. What then about the workforce issues? So we've got a couple of workforce issues that we discuss in the draft report. But any thoughts on particularly the workforce issues for the community mental health sector? Your thoughts first, and then let's have a bit of a discussion about that, if there's any issues you want to raise.

MR STANLEY-JONES: Yes. Look, from our point of view, in the community mental

health sector, there seems to be a lack of acknowledgment of the community mental health sector in the report, and the workforce and its capability. Yes, the workforce does have an ability to provide primary and (indistinct) care, its ability to provide low intensity services, a Stepped Care Model.

Yes, the community managed mental health sector does respond to acute and sub-acute in the form of community special services, and there's a lot of integrated areas, integrated - currently integrated work with clinical specialists, mental health sector and (indistinct) local health and hospital districts throughout the country. Our view is that there's insufficient - it's insufficient in addressing the breadth of the community sector that (indistinct) mental health sector is (indistinct) care or intervention, social inclusion, and emotional and social wellbeing.

But largely, the community mental health sector is invisible in the report, and in our view, if you continue to maintain the medical and health care model - just to give you a bit of an analysis (indistinct) the funding for the sector has dropped off since the (indistinct) mentors and Partners in Recovery program which rolled into the National Disability Insurance Scheme, and, you know, in many respects, the work of the community managed mental health sector unfortunately is lost because it's not clearly defined. It's not clearly identified in the Australian Health Institute - Australian Institute of Health and Welfare reporting.

It's not clear in the Australian Institute of Health and Welfare (indistinct) where the community mental health sector fits. It sort of fits in emergency and ambulatory care, but it's sort of lost, and the capacity to identify the work of that sector is lost. As a consequence of that, and as a consequence of a large portion of funding growing in the National Disability Insurance Scheme, and you've probably heard these numbers before, but there's roundabout 690,000 people across the country who require psychosocial support, and we understand that there's about 54,000 people who will be able to access the NDIS (indistinct).

PROF KING: Yes, yes. Okay. So let me follow up on a couple of things there. So you mentioned things like Partners in Recovery, and we talked about, particularly for people with more complex mental health issues, we've got recommendations relating to navigation, service navigation, care planning, and so on. And one person actually said to me in a hearing, it sort of seems like you've reinvented Partners in Recovery, and the answer was sort, well, yes.

So your thoughts, if you've got some, on that - those recommendations, around care navigation, and also - I'll then come back to a bit on workforce, and then pass over to Harvey, if he's got any questions on this issue. But just firstly, on that care navigation. Do you think we've got that right? That we've gone far enough, or what would you like there?

MR STANLEY-JONES: Look, in terms of feedback from stakeholders, I think that's along the right track. Certainly, Partners in Recovery, from feedback from consumers, carers, and the sector was very positive about the work that happened in the Partners in Recovery space. In essence, it did engage people who ordinarily wouldn't be engaged in the mental health system. So in many respects, it was achieving what it set out to do, particularly for people with severe mental health issues. So people who may be homeless, or at risk of homelessness in particular.

So that sort of navigation that's referred to, I think is along the right track. I guess it was, to me, a little bit unclear about, you know, what the depth and breadth of that service coordination could be. I mean, if it was along similar lines of Partners in Recovery, I think, you know, that would (indistinct) in a much better place to continue to be able to navigate the system.

I think, just along those lines, and a number of you are unsure or - both yourself, Stephen and Harvey, are you familiar with that report in 2015, the Australian government response, it should be (indistinct) driving communities. A review of mental health programs and services. That was distributed by the Department of Health in 2015. Are you familiar with that?

PROF KING: Yes.

PROF WHITEFORD: Yes, we are.

MR STANLEY-JONES: Yes. I mean, that particular document, again, you know, it (indistinct) with, you know, the attempts to - or the support for people, you know, in an integrated system of support through something like Partners in Recovery, and certainly that's - that document, you know, is a helpful guide into - into the impact that - the positive impact that the community managed mental health sector could make. And I think, you know, as far as Partners in Recovery is concerned, and the way the Productivity report has addressed it, I think from our members' point of view is certainly consistent with the positive impact that Partners in Recovery had.

PROF KING: Okay. I was just about to ask exactly the same question, so do you want to do that?

PROF WHITEFORD: So Craig, it's Harvey Whiteford. Thanks for that. We say a lot in the report about psychosocial support, but we have heard from a couple of different people at the public hearings that the NGO, or the non-government community mental health sector's been not well presented in the report. And there seems to be a disconnect between what we've said about the importance of psychosocial support and the essential role that plays, compared to the sector and the people who are delivering that, and some of that appears to be about the - what's happened with the NDIS coming in.

But can you say a bit more about the sector and how it's not appropriately presented in the report, and who the workforce is that makes up the bulk of the service provision in the sector.

MR STANLEY-JONES: Sure. So, as we understand, I have some figures here. In 2017, there were around about 30,000 people working in the community managed mental health sector space. So to define that, that's - that is people who work for NGOs, so not-for-profit, working usually in the non-clinical psychosocial support space. And since 2017, you know, the impact of the NDIS, you know, has had a considerable impact on the workforce as a consequence of that.

And also too in the way in which the work of that workforce, or the outcomes, or the support

for people with mental health issues is identified in that workforce. This is a real issue for being able to measure the strength of the workforce. Largely the workforce is, when it comes to reporting at the moment, is mixed in a range of different streams within the Australian Institute of Health and Welfare reporting.

So at the moment, it's mixing sub-acute reporting. It's also mixing non-ambulatory reporting, and when there's a description of a community managed mental health sector in these reports, sometimes that's referring to government run services that are providing in the community. So it's a (indistinct) to articulate the work of the community managed mental health sector and the not-for-profit work. It's hard to identify currently, as a consequence largely of the funding rolling into the NDIS.

Because there was a view in 2017 that it did need to be recorded or reported anymore. So the impact that the sector has had, you know, up to that point, it was being recorded, although since then, it's not, and during that time it hasn't been clear. I guess what I did - what it did say, that the rate of mental health presentations had - indeed, the Productivity report did say (indistinct) over the past 15 years, and look, we would argue that that's on the back of the community managed or community-based support, and the impact, you know, that that sector had hasn't been - and the workforce hasn't been well supported over that period of time.

PROF WHITEFORD: So Craig, can I clarify something there? We've been told that the minimum data - the NGO minimum data set which was developed by AIHW and then sort of parked, two jurisdictions have collected that data, one of them being Queensland, the other being WA, I understand. Is what you are saying, that that's no longer recorded since 2017? Or is it still recorded, but not compiled and sent off anywhere?

MR STANLEY-JONES: Well, I think there are two issues. That if it is recorded, it's not recorded for the use of the Australian Institute of Health and Welfare, and then secondly, as has been explained from a variety of stakeholders and peak bodies is that if there is any recording of it going on via Queensland Health, for example, or various health departments, or state departments, it's lost because it's fragmented into a range of different service types that don't adequately describe the sector. Don't clearly describe the sector.

So in essence, for example, it's recorded in Queensland Health data and non-hospital data, non-ambulatory data, rather than the (indistinct) data in of itself.

PROF WHITEFORD: Can you pull it out of the Queensland Health data set, do you think?

MR STANLEY-JONES: Well, if you take it - it would take some significant analysis from the department and/or the sector to assist in that process.

PROF WHITEFORD: Yes.

MR STANLEY-JONES: I don't think it is. I don't think - it's not clear. It's not clear to many people.

PROF WHITEFORD: Okay. So I'm not asking you whether you would do it. I just want to know whether it's doable. But it seems a shame that the data is collected, but it's not -

maybe, as you're saying, it's not collected as comprehensively as it should be, but it's not being used.

Can I just ask another question on that then? From your experience and just what you know about the sector, what sort of workers make up the bulk of the workforce in this sector and the second part of that question is have you got any comment to make about Aboriginal mental health workers or cultural capability in that sector?

MR STANLEY-JONES: Yes, sure. So look, the bulk of the sector is made up of people who have, you know, a range of human services, tertiary education in their (indistinct). So the people with social work, psychology, occupational therapy and in some cases nursing backgrounds.

But generally, they're social work, psychology OT's. And then there's obviously, in some - more recently, I think, in terms of - in terms of the workforce, you know, (indistinct) because at the moment the core funding for the sector comes through the NDIS and it's just not possible to employ people for that period and capability in the psychosocial sector, the non-clinical sector as it once was.

So there is a - I think the bleeding of people with - that (indistinct), that background, that capability, largely going - going into Government, for example. There are a small number of psychiatrists and GP's who have come into the sector, a very small number and they're connected through the not-for-profit sector through specialists, step up, step down programs, through Headspace, for example, but really that - you know, negligible in the scheme of things.

And you know, in many instances, if that was a larger - larger church affiliated church-based organisation, they're much larger NGOs to continue to prop up, if you like, the NDIS sector. Or the NDIS supports.

In many respects, and you've probably heard many of these instances, but there are, you know, very successful mental health NGO's, national mental health NGO's that have invested millions of dollars per year and if it goes flat, of course, before the (indistinct) recently, I'm also employed by an organisation that had 3000 staff across mental health affiliations that they'd already (indistinct) that we have just (indistinct) also the drug (indistinct) disability space as well.

It's just we're not able to provide the service and (indistinct) at an organisation (indistinct) they'd have to say (indistinct) a small number of (indistinct) each year and - and we could no longer (indistinct) that, so - but (indistinct) workforce (indistinct) suspect that it's - it's very difficult to say the least in the current environment where NDIS is largely focussed.

PROF KING: So can I - can I follow up a little bit on that before we move to the Indigenous workforce in particular, but for that general workforce, we made obviously the recommendation about contract lengths being extended for the - for the community supports which is hopefully to partly address some issues of workforce job stability as well as contract stability.

But what are the specific recommendations would you want us to make to the Government in May about the community based community mental health workforce? What recommendation is there that you think would help move the sector forward?

MR STANLEY-JONES: Well, in terms of the workforce and the workforce being connected to, yes, people – people with a psychiatric disability, people with – for their specific mental health issues. I mean, there – and people with moderate – moderate to severe mental health issues, who will miss out on the NDIS. So (indistinct) to address those needs. We would recommend – the sector would recommend that funding for people who are ineligible or unable to access the NDIS, we would recommend funding that supports people with moderate to severe mental health issues, and to take pressure off the hospital system. The hospital system in each state, the ED department in each state.

And there needs to be support there for the workforce of people in their not-for-profit sector. I mean, the not-for-profit sector does provide services – does provide services more cheaply or more effectively than the government paid services. Now, in order to prove that, we did the data through that.

But there hasn't yet been a range of reports dating back – dating back to the early 2000s when it came to the Queensland-made report that was commissioned by (indistinct) and they've got their Queensland (indistinct) research around how the support program and the impact of supporting people in the community and in their own homes, whether it was spending, you know, up to a year in and out of ED departments and you know, (indistinct) residential (indistinct).

PROF KING: Sorry, Craig, have you got reference for – to Tom Mien's work on that that you can point us to? Or we could contact Tom directly, I suppose.

MR STANLEY-JONES: Yes, I'd have to contact Tom directly. I know the report – the report was that there was - you were the (indistinct) support program (indistinct) and Tom did a 10 year studying over – over the course of the mid-nineties to the early-noughties. And I think he released his final report actually in in 2010, but I – yes, Tom would be the best to answer that.

PROF WHITEFORD: Okay. We'll follow up with Tom.

PROF KING: Can I also just – I just want to make sure that I'm hearing you. So one of the things we heard in Broken Hill in particular was they said, 'Well, your money and more resources going into one thing. Fill the resource gaps that have been left by the NDIS. But the view also in Broken Hill was that once you get outside the capital city, so that the workforce isn't there. So just putting in money by itself is not enough.

And so I was wondering if you had any thoughts on that? I mean what do we need to recommend to the Government, not just in terms of we'll pop the money out there, what do we need in terms of a workforce strategy so that, you know, Rockhampton, Bundaberg, right up the coast, right through, you know, go out west in Queensland, so that, you know, so that the workforce is there, because you can pump dollars in, but if there's no one to deliver the services, you're not going to get anything.

MR STANLEY-JONES: Yeah, yeah, I mean that's a – a significant challenge as you rightly identify. I think in terms of pumping money to the regional and remote areas, certainly if there's – if there's appropriate services, so I'm thinking of a place like Rockhampton, for example, where I know that the State Government has recently invested in step up step down facilities and built facilities to assist these transitioning people (indistinct) mental illness, out of hospital and into the community. I mean, that's one end of the spectrum.

You know in terms of the (indistinct) and in terms of the – people with moderate to severe mental health issues. I think – I think, (indistinct) like that does encourage, you know, people with tertiary qualifications to you know, moving to reasonably remote areas. I mean, it's part of a wider vision. There's no point challenging that we have answers to (indistinct).

But in the sense of the cost of living, obviously, the cost of living in reasonably remote areas, I mean, that will always be an attractive feature and I know that, you know, Queensland Health and various State Departments throughout the country, you know, who tend to employ people locally, also attempt to employ people from overseas, while being a local capability, is there, so it's open ended.

Enacting a whole range of possible responses in terms of addressing perhaps the lack of inappropriate workforce capability in rural and remote areas, certainly, in terms of like, coming back to your question: are there (indistinct) relation to social and emotional wellbeing in the Aboriginal and Torres Strait Islander workforce.

Again, from a service point of view, (indistinct) I don't suspect that they'd all say from the perspective of the Queensland (indistinct) of mental health, yeah, we were work closely with a range of Aboriginal controlled services and will be, as a (indistinct) service, for example, we work in partnership across a range of programs, Government (indistinct) services are.

It is also a challenge for the not-for-profit Aboriginal and Torres Strait Islander social management and (indistinct) services to (indistinct) when there's competition here from Government sector and Government sector generally pays better. So just recently, we employed two Aboriginal and Torres Strait Islander staff at - just from a personal point of view, for the organisation I work with. We work in a homeless space, we employed these two Aboriginal and Torres Strait Islander staff in May and by August they were offered you know, positions that they couldn't knock back and took up those positions in the Government, you know, for better pay that you know with 15 to \$20,000 greater.

So it is a challenge for the not-for-profit-sector to maintain good – yeah, what we've worked – catering for staff in the Aboriginal and Torres Strait Islanders. But it is a – is expected as quite robust, certainly from a Queensland perspective. And no – yes, from our perspective, there are organisations that we work very closely with – yes, the likes of – in Queensland, in Brisbane, the (indistinct) place, Institute of – IUIH. Institute of Urban Indigenous Health.

And there's enough of a range of other organisation that we also work with here in Brisbane, and to pass the (indistinct) as well. Was your specific question in relation to social,

emotional, workforce and Aboriginal and Torres Strait Island workforce as really about how that workforce is maintained?

PROF WHITEFORD: Yes, no, I think what you've explained there is supports what we've heard in other places and obviously to – it's a challenge in the area.

MR STANLEY-JONES: Yes.

PROF WHITEFORD:

I think that's all I had, Craig, so thanks very much. That was very useful so I appreciate you taking the time to be on the call with us.

MR STANLEY-JONES: Pleasure. Thank you, thanks for having me.

PROF KING: Thanks, Craig. Thank you, we'll log off.

MR STANLEY-JONES: Thanks, Stephen. Bye-bye now.

PROF KING: Bye. Bye. John, would you like to be on next?

MR PINK: Yes. Over here?

PROF KING: Yes, if you could just sit there and - - -

PROF WHITEFORD: John, this is (indistinct words).

PROF KING: Yes, but the air-conditioning's going to blow us away before morning tea, otherwise, so. Morning John. If you'd be able to state your name if you are representing an organisation, what organisation you're representing. And if not, that's fine. And then any open comments that you'd like to make.

MR PINK: Okay. My name is John Pink and I just want to - - -

PROF KING: Now, I think you're about to show a diagram.

MR PINK: Yes.

PROF KING: The only thing is, if you can explain in words anything you want to show, because obviously the transcript can't see the diagram.

MR PINK: All right. Yes. Okay. Name's John Pink. I'm completely out of line, no organisations except the one that kicked me out. So you won't have to worry about me expressing someone else's view. Now, what was the third thing?

PROF KING: Then just any opening comments you'd like to make.

MR PINK: Yeah. The main thing is to the productivity commission, I put in a very simple, I guess you'd call it, chart, right? It's a table and I'll read the opening sentence on the table:

Mainstream Psychiatry is Exposed as Being Unscientific as it has No Answers to Very Basic Questions.

These questions and the questions are up there, there's one column on the left-hand side of the sheet, concern quite well known phenomena associated with mental ill – well, you call it mental illnesses. I don't. I call it mental development.

PROF KING: M'hmm.

MR PINK: I got my book open and one thing I noted down is no one has ever dealt with this and I think you should consider these people who have mental illnesses as a resource, rather than a consumer of money and therapist time and all that sort of thing. I think you should consider them as a resource.

Now, you shouldn't consider me as a resource. You've already lost – I'm already gone. I'm – I'm off, right? But these other people who are suffering mental illness are actually lower down and they've yet to do – to advance onto what I'm doing, right? And I consider these people who have mental illness too advanced to do this test. It's a test and when you're through the test your mind is more powerful. You can do more, cope with more, and you've got to be more careful of how you use it.

And it's such a – although it's a difficult experience, I have a lot of compassion for people who are going through it, and the people that care for them, they're also very special and they should note down everything that happens in a journal and one thing I regret not doing is journaling, right, everything that happened because it's possible later on they'll want to track exactly what they did.

I certainly want to track it, right. And one particular thing I – which I can't get, right, is from a university. And the university was Macquarie University - see there are some people that agree with me - or I think no, right, these people are actually gifted already. You've got to be gifted to have a mental illness, right.

And this one was Professor of Psychology at Macquarie University on Northside of the Harbour. Don't worry I'll stick it in an email, right? Now, I can't remember her name, but she was quite young to be a Professor. But she did one thing which - on the second week – and I remember it's the second week because there was a drawn Grand Final at the Sydney Cricket Ground.

PROF KING: Okay.

MR PINK: And I would have been late for this session, right - there were three sessions over three separate weeks on the Saturday, starting at 4. I would have been late because that's when the Grand Final finishes at 3.20 or something like that. And the only reason I wasn't late was I was drawn.

And it was Paramatta and St George, I believe, right? The year was 1977 and they were drawn at full-time, they played 10 minutes extra time and they were still drawn so it had to play the following week and the second – this was the second week of the course, right?

Three consecutive weeks, it was run over. And she put these probes on her head which measured brainwave activity, so she said, I don't know if they did, right, but so she said.

She put them on, I think, with petroleum gel, we didn't have the water-based gels then, and she used surgical tape - and you just rip it off and stick it on - and she told us the readings to expect and my reading was double the reading that - that she told to expect.

PROF KING: Yes.

MR PINK: I remember sitting there at the time and thinking, 'But I'm not relaxed.' I'm a pretty nervy sort of guy. Even after I've recovered, I'm still nervy. Yeah. That's not changed. I'm not as bad as I used to be, but I'm - anyway, I claim she knew that people's minds are more powerful and the evidence for it is that they've had a mental - they're having a mental illness. They're struggling through. Now, I - I see it as an empowerment process.

That's probably the most important thing I've got to say. There's another one, if you want to check on resources, there's one guy I'll refer you to, that's Robert Whitgar and he's written a -
- -

PROF KING: Sorry, Robert?

MR PINK: Whitaker.

PROF KING: Oh, okay.

MR PINK: I'll stick it in the email, right?

PROF KING: Yes.

MR PINK: He's the founder of Mad In America. For eight years, we've campaigned to have something done at - again, I think it's - I'd say now biological psychiatry where they give them pills to cure them. Right? And he's saying that you give them the pills and it makes it worse. But I still dig up new stuff out of his stuff and I don't think he sees the value of it, right? This last report I've got he's saying after three years these people that are only given the pills improve dramatically. Now there's one psychiatrist, he was called the lead or - and is called the lead, and in another obituary in the newspaper he was called the leader psychiatrist for the twentieth century. He was Dr Karl Menninger, M-e-n-n-i-n-g-e-r, and he run a more easy going institution called the Menninger Foundation. He noticed in these people - and it was - I think it was over 35 years ago he put it in his newsletter, he actually produced a newsletter for the mental health patients to read and that, you know.

He had in there - in the newspaper, he noticed that some - and on the successfultschizophrenia.org website, right, and it's a west coast of America based group, won't talk to me which is typical for - I'm a total loner, I've no allegiance to anyone, no one accepts me. He said he noticed somebody's long term place if recovered - and he said not just recovered but after they'd recovered they went on to do some really outgoing things like establishing businesses and all these sort of thing, right?

PROF KING: Yes.

MR PINK: He termed it weller than well. I wouldn't term it weller than well. I would term it they were initiated, and it's a word I - when I first encountered it I'm reading this word and this is a strange word and I finally got to understand what the word means, and I've produced a diagram but you didn't get the - I've sent it to Bill, right?

PROF KING: Yes.

MR PINK: But it didn't go in (indistinct). I only put this one in. This one has very - - -

PROF KING: Sorry, just again for the transcript. Now you're back to the first diagram.

MR PINK: First diagram under lack of understanding.

PROF KING: Yes.

MR PINK: My claim is the lack of understanding and what's fundamentally going on when the person is going through what you call mental illness. I call it mental development, and I'll go through some of the questions. Why is it common for people suffering from a mental illness to hear voices? It's the first question they ask you when you go to the hospital, 'You're hearing voices?' The second one - and this is - actually there's two, one's a guy who's a psychiatrist in England. Right? (Indistinct) if it's the UK. Dr David Kelly is his name. He runs the livingwithschizophreniauk.org website and on one of the webpages he's got - I think the figure is - he notices people with mental illness have this religious delusions and I think he may say the figure's actually 50 per cent.

Now, it's also in ResearchGate, right, and I'll give you think link to that. There's a psychologist, he was a lecturer in psychology at the University of Arizona, and I forget his - I think I forget his name, but I can get it.

PROF KING: John, so I take your perspective and I want to - and I can see it's a perspective - I can imagine many people would sort of not have the same perspective, but I want to see the importance of the perspective for outcomes. So let's put the pills, the pharmacological treatment, to one side for the moment.

MR PINK: Yes.

PROF KING: So, as you said, you do it as a test, and they may be struggling during the test. With your perspective, would you say, well, they should be helped in that test, so there should be the community-based services to help them whilst they're going through that test? I mean, so would your submission to us be, well actually, we need the support for those community services, whether it's employment services or services in school, or services in housing.

From your perspective, they're going through a test, but it makes it easier for them to go through the test. Would you see that as a legitimate role for government, to fund those sort of community services for the people going through, as you said, the test?

MR PINK: Yes.

PROF KING: Okay.

MR PINK: Look, I went best away from my therapist, really, and the good thing, when I say I had a therapist, I had Jungian analyst, and I even moved away from him, simply because I had so much trouble with the psychologist. I've found these mental health experts, or the mental health professionals, to be that control-freaky, I couldn't stand it. You know, and I think I'm fairly tolerant. Now I've got nothing but praise for them at the start of my treatment. In fact, my recovery may not have happened, or certainly wouldn't have been as powerful, without their involvement, and I still wonder to this day why they behaved like they did.

In other words, their behaviour was that poor at the end, from this excellent, nothing but excellent treatment at the start. It was phenomenally good. It was brilliant, yes. But I noticed, as I started getting better, I started having more and more problems with these people, you know. And look, there's a guy I'll refer you to, is Lanny Beck. What happened was, Pierre Trudeau, they deinstitutionalised in Canada and in the UK, right.

PROF KING: Yes.

MR PINK: And in Canada, you're allowed to apply for money to establish things. Well, they were given money and they purchased a house, right. And they also collected from the people they were getting their dole benefits, or whatever the equivalent is over there. In the end, they were called the Mental Patients Association. They owned half a dozen houses. They actually did a film on it.

PROF KING: Yes.

MR PINK: And I'll send the link to the film. They won't talk to me, but I'm pretty sure they'll talk to you. They actually made a film with these people. I told you before, they were very gifted. Give them the money; this guy Beck organised them and they owned half a dozen houses when they shut down.

PROF KING: Okay.

MR PINK: I mean, you know, that's not silly. That's very controlled. Clever.

PROF WHITEFORD: So John, thanks for what you've discussed with us. I think it's important. What I heard that you said, which I think is important, is that we have to think of people who have been through those experiences as a resource as people who can provide information that we don't otherwise have.

MR PINK: Yes.

PROF WHITEFORD: From a perspective that people who haven't been through that experience don't have, and listen to them more about how we can make the services better.

So, from that point of view, I think what you said does resonate, and thank you for taking the time to come all the way that I understand you have come to be able to be here and present.

MR PINK: Glad to come here. Look, I'd even say more than you, I'm seeing - these people will produce dollars for the country, right, because they are that clever. They're the top of their line. They're the top. You know, not just they've got a lot to say about the treatment, right. I don't think these people say much about - they'll just get on with it and produce money for the country.

PROF WHITEFORD: Great.

MR PINK: I mean it. I think these people are clever. They were clever before they had the mental illness, and the mental illness (indistinct) they were clever.

PROF KING: One last question from me, and it's on the medicine side. So we've heard from different people their experience with the medicines, and some have said, yes, but they don't think the medicines work for them, and so on, which you - would agree with your position. We had other people who said, gee, if - well, one example we had, someone said, look, if it wasn't for the medicine, I'd be dead now. That they were suicidal and the medicine stabilised them. I mean, is it always the case that the pills can't help, or is it just a matter of sometimes they help, sometimes they don't.

MR PINK: I'll refer you to Yale University. They actually had a placebo department, and what they did was they measured - I think it was a double-blind test, right. They found there was a two per cent difference - two per cent improvement in mental condition, right. Only two per cent, right, from taking the pills, the ridgy-didge pills, or purported to be ridgy-didge pills, right. The clinician, they also said, has got see a seven per cent improvement before they notice it, before they pick it up.

PROF KING: Okay.

MR PINK: They actually have got a video where they - where they're marketing this - these placebo pills because they consider that as long as they don't claim they're a legitimate antipsychotic drug, right, they can market them. But they found, even when then tell people it's a placebo, there was improvement. Yale University's the one to talk - don't talk to me. You know, I don't know much about the pill.

PROF KING: All right. Well, thank you, John.

PROF WHITEFORD: Thank you, John.

PROF KING: Thank you very much. Thank you for coming so far to talk to us.

PROF WHITEFORD: So can we get a copy of the - the one you didn't give to Bill, if we could get a copy of that for the - - -

PROF KING: Yes, if you can get a copy of that to Bill, that would be fantastic.

MR PINK: Yes, I'll just email it to Bill.

PROF WHITEFORD: Yes, thank you very much.

MR PINK: (Indistinct). You're obviously going to have no one turn up this afternoon. I'm only staying to talk to people, right. I may as well clear out now.

PROF WHITEFORD: That's fine by us.

MR PINK: Otherwise - - -

PROF KING: Up to you.

PROF WHITEFORD: Whatever's easiest.

MR PINK: I don't think anyone's going to turn up, so why put your people under stress.

PROF KING: All right. Thanks, John.

PROF WHITEFORD: Good on you, John. Thanks for coming.

MR PINK: No, thanks for accepting me.

PROF KING: No, thank you.

MR PINK: Thank you.

PROF KING: Next, we've got Dean, I think.

PROF KING: Dean, if you don't mind introducing yourself for the transcript, stating your organisation and any opening comments that you'd like to make.

MR HYLAND: Thanks, Stephen. Good morning to you all. My name's Dean Hyland. I'm a registered nurse and a credentialled mental health nurse. I'm currently the centre manager at headspace in Bundaberg, and have been in that position for the past eight months. I'm attending this morning as an affiliate of both headspace and also the lead agency for whom I work, and that's United Synergies.

I would like to start by acknowledging and paying my respect to the Darumbal people, the traditional owners of the land on which we meet. I would like to pay my deepest respects to the Elders past, present, and emerging, and acknowledge all the Aboriginal and Torres Strait Islanders here today, also paying my respects to the Elders past, present, and emerging.

I'd like to thank the Productivity Commission for the opportunity to speak today, and applaud the Federal government for undertaking such a significant and important review. I'd like to highlight to the Commission, and assist it to understand, that often the mental health of young people, or young Australians, is the key to the nation's productivity and economic success.

Whilst I'm in no regard an expert, I've been indeed fortunate to have worked in rural and regional Victoria, rural and regional NSW, Darwin, east Arnhem Land, Cape York, and now in Bundaberg, in the Wide Bay area. I've mostly worked in the area of community-based mental health, and mental health and drug and alcohol treatment services, both government and non-government agencies. Prior to relocating to Bundaberg, I was a clinical manager for the first service, or health service in Australia that incorporated two states; both Victoria and NSW, and that's in Albury-Wodonga.

Headspace, formally the National Youth Mental Health Foundation, is an Australian not-for-profit organisation for youth mental health, established by the Australian government in 2006. Headspace is funded by the Department of Health and Ageing under the Youth Mental Health Initiative program. In speaking this morning, I'm hoping to assist the Commission to understand that optimum mental health of young people, or young Australians, is the key to the nation's productivity and economic growth.

The general public understand headspace primarily offers mental health service to the 12 to 25-year-olds with low to moderate mental health issues. Headspace actually delivers a whole lot more than that. Headspace provides support to young people aged 12 to 25 to reduce the impact of depression, anxiety, stress, alcohol and drug use, and to improve relationship issues associated with sexuality, sexual health, families, and bullying. Young people and their families can also receive support at headspace centres, as well as online and telephone supports such as eheadspace.

At a localised level, headspace is involved in community engagement opportunities through a multidisciplinary approach and supported and guided by a consortium of local, non-government and government agencies. The importance of early intervention and detection needs to be a priority area for the positive impacts upon the mental health of young Australians. A brief background you're probably all aware of. Headspace, and the positive it's had on young people, is the following.

So since the inception in 2006, headspace has supported over 250,000 young people over 300 million - sorry, three million services. In the past year alone, 99,892 young people received support via headspace, including out of those over 9,000 Aboriginal and Torres Strait Islander young people, almost 11,000 culturally and linguistically diverse young people, and almost 26,000 young people who identify as LGBTIQ plus.

More than 62 per cent of young people get better with headspace, and this increases to 68 per cent if they attend five or six more sessions. Young people report higher levels of satisfaction with services, such as headspace 85 per cent, headspace centres 87 per cent, and headspace early psychosis 94 per cent. 77 per cent of young Australians recognise headspace and they know that that's the place for them to go.

A recent follow up study of more than 1,900 young people found that young people's distress levels and functional recovery improved using headspace, and continued to improve for more than a year after that. The majority of participants reported high or very high levels of psychological distress upon entering headspace. All age groups reported a decrease in psychological distress using the Kessler 10 whilst at headspace, and most age groups reported

further improvement after leaving.

Most participants, total 84 per cent, reported that headspace positively impacted their mental health, literacy, and helped them better understand their mental health problems. Participants also reported developing skills to deal with mental health issues, highlighting the important role that headspace plays in equipping young people with the tools and the resources to better manage their day-to-day mental health. And importantly, 78 per cent of participants reported that headspace has positively impacted on their work and study situation.

Headspace in Bundaberg is a partnership of local health and government service organisations provided under the auspice of United Synergies. They are my lead agency and their head office is in Tewantin. Our aim is to provide full integrated, free, primary health care services for young people in one youth friendly environment. Each centre is slightly different in its approach to service delivery, because the centre is guided by local community needs. Each centre has a youth committee that provides a youth specific lens and is directly involved in the running of the centre. Each community has differing needs, and therefore requires custom made interventions and responses.

I'd like to share with the Commission some relevant statistics that are more and directly - that are important and directly impact upon the youth, particular in the Bundaberg and Wide Bay–Burnett, Fraser Coast area. So the Bundaberg, Wide Bay–Burnett, Fraser Coast area, the median age is 46.7 years of age, but Queensland is 37.3. The median annual household income for the Wide Bay–Burnett, Fraser Coast is 58,930, whereas the Queensland state government median family income is 86,000.

Bundaberg has 33 per cent of households with a child under 15 years of age that do not have a parent or parents that have ever been employed. For the rest of the states, that's 24 per cent for Wide Bay, and for Queensland, 13.8 per cent. In many cases, those young people have never seen a parent get ready, prepared, and go to work. The state average percentage for young people completing Year 12 is almost 60 per cent, against 41 per cent for the Wide Bay–Burnett, Fraser Coast.

Given these few statistics, the Wide Bay–Burnett, Fraser Coast, and in particular, Bundaberg, could well be regarded as an area of disadvantage. The local community has a couple of fantastic programs I'd like to inform you of. One of these is accessible trial program, the Individual Placement Support.

PROF WHITEFORD: Sorry, IPS?

MR HYLAND: Yes, IPS.

PROF WHITEFORD: We're aware of that.

MR HYLAND: Yes, so the IPS. The other pilot program within secondary is called Link and Launch. Link and Launch is a pilot program that is being conducted within the six secondary schools in the Bundaberg area. The project is running for a period of three years and will complement and value-add the Individual Placement Support program, which has been trialled within 45 headspace centres.

Headspace Bundaberg has a close working relationship with the local secondary schools. Regular and consistent follow up for two years after leaving Year 12 is part of that Link and Launch program. In 2018, there were 662 students that completed Year 12. Of those 662, total of 143 had no plan for employment or plan for ongoing study after Year 12. Of those 143, 129 had never had any form of employment whilst at school. Given this, if young people gain some form of employment during the school years, they have a far better chance of securing employment after leaving school.

On September 10 2019, Angela Jackson from the Sydney Morning Herald reported that Prime Minister Scott Morrison noted the best form of welfare is a job. It is a widely understood and accepted fact that poor mental health or mental ill-health strongly correlates with high levels of unemployment and lower levels of education. The result is a greater burden on the health care and welfare systems, as well as the economic and productivity status of Australians.

Early intervention and the prevention of mental illness is vital to the entire socioeconomics of our nation. Prevention and early intervention of young people who experienced mental health issues, the adage is, a stitch in time saves nine is truly relevant, as we all know it is far easier and more cost-effective to prevent a crisis, as to deal with one. Therefore, the headspace model of early detection and early intervention really, really works.

The Individual Placement and Support Program, the IPS, which supports young people with mental ill-health to engage in work and study, is another successful trial program within headspace. From my perspective, and that of headspace national office, this program is a vital service that must be incorporated in all headspace centres.

Improving the mental health, particularly of young people, has a positive outcome for that young person, and the productivity and socioeconomics of the population, and I congratulate the Commission on also recommending this as part of their draft recommendations. Hopefully, for Bundaberg and district, headspace Bundaberg will be approved for an extremely - for this extremely successful program.

The Productivity Commission, in its draft report, acknowledged that 75 per cent of mental ill-health cases first appeared before the age of 25. Because of this, the Commission has prioritised prevention and early intervention as one of their five reform areas. I also congratulate them. There are a number of Commission recommendations that I would - that will have a positive impact on the mental health of Australians, and these include providing more outreach and mobile home treatment services for individuals experiencing mental ill-health, as alternatives to emergency departments.

Progressing the rollout of the Individual Placement Support program to support young people with mental ill-health engage in work and study. Strengthening our youth peer workforce and providing assertive follow up support for post-discharge after suicide attempt. However, I believe there are some missed opportunities within the draft report, some of which I will briefly touch upon.

The first one is a missed understanding of the strengths of headspace platforms, especially the

localisation of headspace centres, and how embedded they are in the local communities. Headspace Bundaberg, as with most centres, are created on the need and the groundswell of support from the local community, and concerned individuals and service organisations. This service was created by those people because of community needs. My centre was and still is driven by the voice of youth and the needs of the local community as identified.

The second point is, the extent of engagement with young people and their families - with young people and their families and friends. The prevention and early intervention of the young person's mental health is also greeted with benefit through the involvement of the family and friends. Headspace encourages the family and friends in the participation of the recovery, and provides opportunities for the young people to share their lived experiences in safe and supportive forums.

These forums include information sessions for the family and friends of the young people, allowing them to better understand the issues faced by the young person today. Family and friends are also included within the consortia, as they provide a perspective that has a great impact upon the young person. It is also important that the family and friends are also included in any discussions about youth mental health reforms, and that occurs through the consortia.

Given this, I strongly encourage the Commission to take up headspace's offer to meet with young people, their family and friends, and also the headspace clinicians. The third point is the significant impacts that the timing of the first onset of mental disorders in adolescence and early childhood can have on the young person's life. The transition between childhood and adulthood is a crucial time in a young person's life, and developmental periods for education, employment, and interpersonal and relational outcomes.

The timing of the first onset of mental disorders in adolescence and early adult can have a significant social and economic impact. It's at this age, and the stage in life that young people are, engaging in education that will have a formative - in their social connections and future pathways to employment, experience major life transitions, including moving between levels of education, from education to employment, away from their families and caregivers, into independent living arrangements. Developing and navigating new social connections and interpersonal relationships is also a point.

The last point I'd like to raise is the importance of reform for mental health to comprise youth mental health. Many of the recommendations in the draft report were framed around child and adolescent and adult age paradigms, and not youth mental health. However, it is imperative that any reform to mental health specifically comprise youth mental health. It is reiterated by young people who tell us they want the services that are youth friendly, recognisable and safe, which is why headspace is a service developed by and for young people aged between 12 and 25.

So, before summary, I would also like to voice my concern about the employment of suitably qualified professionals to work within the mental health sector. The Medicare Benefits Scheme provides the opportunity for psychologists, mental health social workers, and mental health occupational therapists to provide psychological interventions. Being a credentialled mental health nurse myself, credentialled mental health nurses are not included within that

Scheme.

I would like the Commission to note this and consider the inclusion of mental health - credentialled mental health nurses are provided under the same category. There is a number of very experienced credentialled mental health nurses not being utilised to their full potential. The hiring of allied health professional for access onto - or into an allied health professional for interventions under a mental health care plan is extremely difficult, and this would provide a welcome relief and addition of - a number of additional professionals.

I would again to thank the Productivity Commission for the opportunity to speak today, and applaud the Federal government for undertaking review. I would like to reiterate to the Commission that optimum mental health of young people is the key to the nation's productivity and economic success. The Productivity Commission is in a position of leverage for the voice of young Australians, so as to build upon the Federal government's investment in young people's mental health, including the headspace platform.

Finally, I would like to the Productivity Commission to work with headspace to engage with the diversity of young people who access headspace services to help inform the Commission to develop a final report, which is due in May 2020. In summary, I've highlighted the fact that mental health ill-health usually has its onset during the years between 10 and 24. Poor mental health has a detrimental impact on, and places huge pressures on, the health and welfare systems, and ultimately on the productivity and economic - economy of the nation.

Poor mental health is effectively addressed with early assessment and intervention, and headspace is the preferred and recognised youth specific service that works with young people at local areas. Thank you.

PROF KING: Thanks, Dean. If I can start off. I actually want to deal with - you touched on mental health nurses at the end.

MR HYLAND: Yes.

PROF KING: So let me start with that. So we've got a number of recommendations in our draft report around mental health nurses training. They seem to be one part of the workforce that we need an expansion in. We note the mental health nurses in GP clinics program that was funded and then defunded.

MR HYLAND: Yes.

PROF KING: But you mentioned the MBS, and I will confess I don't quite understand this. That mental health nurses (indistinct) almost every part of allied health keeps coming back to, well, if only we could get the MBS provider number, life would be good. And my reaction to that is, well, MBS provider numbers are fine for - if you're seeing specific services, and if you're not a GP, it's a service under a referral. But it seems to me to be a very narrow, activity-based or - not activity-based, but a fee-for-service funding scheme, and yet everyone says, well, we want to get on that.

Now, I do wonder, does everyone say, well, want to get on that because that's the only thing

that they see as available, versus other funding mechanisms. So I'd like to press you a bit on that. Why the MBS? Why not mental health nurses being funded through other support mechanisms, through contracting processes, through money going to - well, potentially GP clinics or to places like headspace? Why MBS provider numbers?

MR HYLAND: Well, my understanding is that, through the MBS, the (indistinct) and the previous services in GP clinics were funded through the Medicare Benefits Scheme. The issue that we have, and a lot of, I believe, a lot of the headspace centres have, and other - and probably GPs, is that whilst we have clinicians that can do the brief intervention and the assessment, a lot of those young people need a higher level of psychological intervention; CBT based, which can extend over, you know, five or six sessions.

Particularly in Bundaberg, we are limited in who we can actually refer to, and I hear this far and wide. And previously, as a clinical manager in Albury-Wodonga health, we had the similar situation where GPs didn't have the access to the allied health professionals because there weren't enough of them. So my understanding is this is another way of getting professionals, with a background and understanding of mental health, in to provide those services.

PROF KING: So do you see the mental health nurses providing psychological counselling type services?

MR HYLAND: The same service as what social workers and occupational therapists and psychologists.

PROF KING: Okay, okay. Yes, okay. Would that be the only area where mental health nurses - because I guess we were also looking at mental health nurses as things like care coordination. I guess we were thinking of them in a much broader role. Were we wrong to think about them that way?

MR HYLAND: No, look, I guess I'm biased, because I'm a registered nurse and then a credentialled mental health nurse. I believe that we have a greater understanding of medications, the physiological impact of mental health, and also from a bio psychosocial aspect. And this is in no way disregarding or lessening that of a psychologist or a social worker or an occupational therapist; they don't have the background or they don't have the understanding, the physiological understanding, in a lot of the cases that the nurses do have. So the majority of the allied health professionals work from a - not from a bio psychosocial, but a psychosocial aspect.

PROF WHITEFORD: Can I just follow up on one question while we're on nurses? So one of the recommendations in the report was around introducing a undergraduate mental health nurse qualification, and we've had different feedback from different, I guess, parts of the nursing sector, and from individual nurses about the pros and cons of that. I'd just be interested in your perspective about having that available for nurses, as well as a postgraduate qualification in mental health nursing.

MR HYLAND: They have the similar qualification for midwives. So I can't see why they wouldn't - or why they couldn't include that for mental health. It is a specialist area.

PROF WHITEFORD: Yes.

MR HYLAND: I've been fortunate enough to do my general nursing, and then postgrad studies in mental health and a couple of other areas, but I think it's vital, and primarily to understand from someone with a low prevalence disorder, if you had the opportunity to work within the acute sector, I think that expands your knowledge to community-based service provision too. So I think providing that undergraduate bachelor's degree is conducted within the acute care sector that involves the community also, I think - I can't see why that would not happen.

PROF WHITEFORD: Okay. I had one other question as well regarding - and jumping back to headspace now.

MR HYLAND: Yes.

PROF WHITEFORD: So, from your perspective, the role of referring to internet based therapies or online therapies, especially I guess for the people who might have challenges accessing face-to-face care as if - I guess in a timely way. Is that an experience you've had in the Bundaberg headspace, or in other headspaces or other areas you've worked?

MR HYLAND: So, telepsychiatry, which is access into a psychiatrist. We have all that services set up in our centre, but unfortunately, we don't have the referrals from the GPs. In the care of our young people, all our clinicians communicate directly with the primary caregiver, the GP, and if we believe that they would benefit from a psychiatric review, or the doctor understands that that might be appropriate, we always offer that opportunity.

But with the GPs at this stage, they would undertake that telepsychiatry review within their surgery. As a headspace centre, we need the referrals from the GPs to actually access the telepsychiatry, and ongoing for the telepsychology, if that's the case.

PROF WHITEFORD: What about online, internet based CBT, where it's not about seeing a psychiatrist or a psychologist, but doing some intensity - low intensity treatment on it.

MR HYLAND: We haven't had that experience. We've got six clinicians who are - can access clinicians. We've got one who is a trainer in Low Intensity CBT, which is fine. The rollout of that LICBT, are you sure - are you aware of that?

PROF WHITEFORD: Yes.

MR HYLAND: So I think that would be fantastic, but it's - from a centre manager's point of view, it's difficult to allow one of the clinicians, or two clinicians, to leave and be involved in the training, where, you know, we have all these young people accessing the service. What do we do? We say, hang on, we have to put you on hold until we get our people trained up, where they're actually educated well enough now to provide broad - broader CBT based interventions.

PROF KING: I want to step back a bit in terms of headspace, and how we should be

thinking about headspace. So headspace is an unusual group of services, if I can put it that way. Because headspace is both a gateway, it's a platform for other parties, such as GPs, psychologists, to provide services on. It co-provides services, and goes out and provides in-community services. You mentioned the Link and Launch program.

MR HYLAND: Well that's a part of the education system, not headspace.

PROF KING: Yes. Okay. It makes it difficult to think about exactly where headspace fits in, because if you're just a platform, a medical clinic which happens to rent out some rooms to GPs and psychologists, that's very different from an actual service provider, and that's different from a gateway that says, look, come in, we've got a national brand, we're recognised, we're a safe place. Come in for your primary health needs here.

And I must confess, I'm struggling with exactly how to think about headspace, and whether it's simply - should we just view it as an octopus that's sort of filled bits of the system because there's nothing else there. So I'm not saying it's a bad thing, but what should be the focus of headspace? What really should it be focusing on? You know, just in terms of Bundaberg, what's the key thing that headspace does that others can't do?

MR HYLAND: Because it's driven by the youth, it's a youth-friendly environment. So the youth of Bundaberg, they feel comfortable in coming into the centre.

PROF KING: Yes.

MR HYLAND: Now, with the stigma associated with mental health, or sexual health, or drug and alcohol, they come into the centre and no one knows where - who they're seeing. So, from that point of view, it's very confidential.

PROF KING: Yes.

MR HYLAND: So it allows them to come into the centre. It's their space. It's got great environment and it's youth-friendly and accessible.

PROF KING: So is it that doorway function that really matters? It's a doorway that people other - you know, if it wasn't there, the relevant young people would just fall through the gaps.

MR HYLAND: I believe so.

PROF KING: Yes, okay.

MR HYLAND: I believe so. The thing is, it's not just a shopfront.

PROF KING: No.

MR HYLAND: We don't have a GP. We have one allied health professional, because we can't get them. If we had a GP that was on there for one or two days a week, which I'm trying to do, and if we had more allied health professionals, the number of young people coming

through there would get a one-stop shop.

PROF KING: Yes.

MR HYLAND: We also work from a no wrong door policy, where everyone who enters the service, whether it's walk in or whether it's a phone referral or an email referral, we always refer them onto the most appropriate person or service.

PROF KING: Yes.

MR HYLAND: But the thing is, it's nationally recognised, and as I was saying in there, it's - young people feel comfortable coming in there because they know the service they're getting.

PROF KING: Yes.

MR HYLAND: Now, whether it's - a lot of young people, through adolescence, don't have a significant or a high prevalence disorder. A lot of this is stress related. The number of the young people that come to see us, the majority of those people, those young people, would be saying they feel validated, they're listened to, and within one or two sessions, then that stress is then dealt with. So it's not a roundabout that - providing the ongoing service all the time. It's around about having them feel comfortable coming into a place where they're non-judged, they're validated, they're listened to, and then they're given that support to be able to move onto the next part of their life.

PROF KING: Okay.

PROF WHITEFORD: One quick last question. Thank you for the time. The Indigenous workforce, do you have many Indigenous clients? Do you have cultural capability within the - your staff you're able to hire for headspace? How does that sort of work?

MR HYLAND: As I noted, I've only been in this headspace centre for eight months. It is building, and I think having the Indigenous workforce and Indigenous people coming into the service, it's around about building relationships. It's about building relationships with the Indigenous community. So that's what we're a part of at the moment. So once that's established, there are more and more young people, young Indigenous boys and girls, men and women, coming into the service, and that's through building those relationships.

PROF WHITEFORD: So just my interpretation of that would be that, in building that relationship with Indigenous communities in the sort of wider areas, important to them being comfortable accessing a headspace service.

MR HYLAND: It's no different than any other area. If people feel comfortable and they feel safe, and they're not judged, then they will come into the centre.

PROF WHITEFORD: Okay. Thank you very much.

PROF KING: Thank you, Dean.

MR HYLAND: All right. Thank you.

PROF WHITEFORD: Thanks.

PROF KING: Let's take a bit of a break for morning tea. There is enough food to feed an army at the back there. We've got five scones each, I think. And let's take a break for - a quarter to, let's come back. So about 20 minutes, a little bit under.

SHORT ADJOURNMENT

RESUMED

PROF KING: And thank you for chatting with us, Bronwyn. Just for the transcript, are you able to just state your name and the group you represent, and any opening comments that you'd like to make?

MS REES: Yes. My name is Bronwyn Rees. I'm actually here today with a support person, Anna Horn. I'm a developmental trauma advocate, and founder of Rise Above ACEs group, which is a Facebook group that we run raising awareness on the adverse childhood experience study.

PROF KING: Okay.

MS REES: A little bit about myself as an introduction, and how I came to be in this position. I come from lived experience of developmental trauma and adversity. I'm 54 years of age. At the age of 60, I decided to sign up for the Royal Commission into Institutionalised Sexual Abuse. At that point, I was able to access my records from New Zealand. The first school reports I read stated that, "Bronwyn Rees is a retard." That – straight away I said, "I told you there was something wrong with me, and I felt that my whole life." My whole life, I'd been in and out of counselling, trying to figure out what was wrong with me, only to be told I was strong.

I'm really sorry. This is where I think the massive file has come, because we're feeling creatures that think. The reason people reach out to go into counselling is because we don't feel right.

PROF KING: Yes.

MS REES: And a lot of the work that we are given is focused on CBT, which understanding brain science the way I do now, that part of the brain is not even functioning in a hypervigilant state. I've lived most of my life in that part of the brain. I've even had to learn how to breathe again, which I thought was amazing, learning how to breathe. Again, these things – if I knew all this information, I just can imagine what my life would have been like, how that would have impacted my own children. The domestic violence that I was in. What

I could have done to protect the transference of those fears, my fears onto my children, which I now see in them today.

PROF KING: Yes.

MS REES: The good news of all this was once I was told it was hardwired, that's really where my journey began. After doing a Diploma of Community Service, walking away again with so many unanswered questions and a lot of it just not making sense, I started research and work was (indistinct) schools. Dr Bruce Perry's Neurosequential model. The (indistinct) addiction. Dr Dan Siegel (indistinct) adolescence, which was really helpful for me, especially because three or four years ago I had a son who was stabbed. I was the way it was handled here. Trying to find support for him. Just every system, every service I approached, they failed my son, and to be honest, I am lucky he is alive and here today, and I believe 100 per cent that my son is with me today because of the information I had researched and was able to hand over to him.

Not long after his stabbing, I was able to tell my son that he may or may not have nightmares, flashbacks, those sorts of things. And it was like – I think it was about three or four months after the attack, he said, "Mum, I had the worst nightmare." He was able to come and talk to me about it, and we were able to have a conversation. I was able to then teach him how to be mindful of his thoughts, of his body, to be able to prepare him. He had many – I think it was five suicide attempts.

He was placed into hospital. On the last time, it was under police guard, they took him in, which I supported, again, to make sure that my son got the right help. The psychiatrist told him there and then, "We could hold you here," and he felt that he needed it, but all they could do was drug him until he said he didn't want to hurt himself anymore. And my son looked to me and he said, "Mum, this is not working. This isn't right," and I said, "I know, I know."

PROF KING: Yes.

MS REES: I'm happy to say that he is now an apprentice. He's completing – he's just completed his second year, going onto his third. And again, it wasn't because of our systems that supported him. I had to go overseas and find the help that I needed to be able to give my boy access. And the people that do know this information, I couldn't afford. So it's not available. It's not out there, it's not acceptable to us.

I think the hardest thing I've learnt since – like four years I've been researching. The hardest thing I think I've learnt in the four years is it's one thing to have all this knowledge, but then you need to be able to implement it. And to actually implement it, you need to have a safe environment.

PROF KING: Yes.

MS REES: Yes, trust, safety within our system and services. I still – I'm written up as noncompliant. That's not it, it's not that I'm noncompliant. It's that I don't get the support or the help that I need. I still struggle to this day.

PROF KING: Yes.

MS REES: I risk, you know – it's been a tough – a tough line (indistinct).

PROF KING: Okay.

MS REES: Have you heard of the ACE study, can I ask?

PROF KING: Sorry, I missed that, have - - -

MS REES: Have you heard of the ACE study, the adverse childhood experience study, done back in the late – 1998, I thought it is.

MR WHITEFORD: We have all that here. We have those studies, and similar ones that have been done on individuals who've been exposed to the adverse childhood experiences, and we've also spoken to - - -

MS REES: I think that, you know, the way I looked at the ACE study, you don't have to have ACEs to benefit from ACEs. ACEs is not a program, it is a mindset. It is a way of being. It is changing the way that we view people. You know, like if someone is having a go at me, I don't take on their behaviour as a personal attack on me. If anything, I stop and say, "Wow, what's going on in that person's life for them to be reacting the way that they are?" Because if I react to that, we're not getting anywhere.

PROF KING: Yes.

MS REES: If I try and – if I then wait until that person is back and regulated to their own – to baseline, I should say, we can then have that conversation and work problems out.

PROF KING: Can I just follow up on what you've just said there? Because I want to understand – so the system failed yourself and you said also the systems failed your son. But I want to understand exactly why. So did the system failures reflect that the relevant clinicians here weren't appropriately trained, they didn't understand the techniques?

MS REES: Yes. Yes.

PROF KING: Yes – oh, and/or, before you say yes, but and/or, is it also – was it that the clinicians here didn't actually have the right view of the people they were trying to help? I mean to what degree – was it both, or one or the other? Yes, I'd really like to understand why the system failed.

MS REES: (Indistinct) both of what you're saying there.

PROF KING: Yes.

MS REES: Lack of knowledge. This brain science is epigenetics, neuroscience, is fairly new.

PROF KING: Yes.

MS REES: So lack of information there. Now we're all talking about trauma reform, and I know people that have done the training through Blue Knot Foundation. Their services are now claimed to be trauma reformed. I've been in these services and I will guarantee you, they are not trauma reformed.

PROF KING: Okay.

MS REES: So what I'd like to see is how we can monitor our systems and our services to collaborate, collect data, and do you know what I mean?

PROF KING: Yes.

MS REES: When I say ACEs, understanding neuroscience and epigenetics gives you a different perspective. So you're not looking at the person as though they're the problem. Like my son's reactive behaviour, like he got threatened with being locked up and everything. And (indistinct) there it was just the kids acting from a place of fear, it's coming from fear, then act accordingly.

PROF KING: Yes.

MS REES: Don't threaten. Because you're just adding then to his already fearful state.

PROF KING: Yes.

MS REES: And the ACE questionnaire, what I like about the ACE questionnaire, it collects data, or a service is one, what they were using. It was to collect data to – hang on, just while I find it.

PROF KING: Yes.

MS REES: Page 1.

MR WHITEFORD: So while you're looking, can I just ask a question that will fit into this? So one of the issues that's been raised about the draft report we've released is that the recommendation for more trauma informed care needs to be built into the changes to the system. And what you're talking about would be consistent with that, is that what you're suggesting?

MS REES: Yes, definitely.

MR WHITEFORD: Yes.

MS REES: Definitely, but that's just part of it.

MR WHITEFORD: Yes.

MS REES: You also need to add in, we want trauma informed services. Yes, I support that 100 per cent. But without the ACEs science, epigenetics, neuroscience, the ACE study findings, the resilience, post-traumatic growth, without that added into it, you've only got half the picture.

PROF KING: So could you just talk about that a little bit more then? So what would have to happen to build that in as well?

MS REES: Training.

PROF KING: Training?

MS REES: Educate (indistinct).

PROF KING: Training of clinicians who work in the system, or - - -

MS REES: Anybody. Community. I'm all about community. Do you know, the best people who change behaviour are our parents. Parents deserve to know the largest public health discovery of our time, which I believe is the ACE study. They should have the opportunity to talk about their own life experiences and consider how they might like to use it, and use scientific discoveries to give their children greater health, safety, prosperity and happiness than they had. And I have been able to do that using the science of my own children, with clients that we have helped in the past, and I'm happy to say that everyone's doing okay.

We all have our down days, but we know that we'll get through it. We know that we've got support. We have a tool box of tools. I do, myself. Brain hacks of what I can use to be able to get myself through. It's not a deficit based approach, because it does not ask what's wrong with you. It asks what happened to you.

PROF KING: Yes.

MS REES: So at that point, you end up removing shame and blame. If you want to know why people don't engage, it's because of the shame and the blame. What plays out in our own head is not nice.

PROF KING: So can I ask a follow up question then? So are you aware of services either within Australia or overseas that do have in place those components you're recommending?

MS REES: I'm actually going to be meeting with the state government in the new year to discuss a partnership that I've been working on with ACEsConnection in America. Now on ACEsConnection, you've got access to any information you need. It's a support network for our judges to go to, for our schools to go to, for our services, for parents. Anything you want to know, resources. We do not have to reinvent the wheel here.

PROF KING: Yes.

MS REES: Like I said, I'm about communities, because I think each and every one of us can benefit from this work, and we might have to (indistinct words). Online training, I've done Alberta – the Brain Story Certification. Again, this information isn't available here in Australia, but luckily for me, I found a free online course, and yes, it was really a tough course to do, but I learned so much from it. I also did a (indistinct) on the ACEs training out of Iowa, again, online and free. So all this information is there.

I go on Facebook and I see groups of teachers, and the language used is shameful, it's the meaning. You can just see everybody is at breaking point. And then you go onto a trauma informed school site, where all the information being shared around, like the pages I'm connected to, it's full of hope of what works, you know?

Now we know the punnet of measures do not work. Jim Sporleder from Walla Walla High School, I'm in talks with him from Washington. He was the very first to implement this model using the ACEs (indistinct) in his high school. Now I can – I'm happy to say that after I think three years, there's no more expulsions. Better attendance obviously, and kids are actually with an average of 5.5 on the ACE data. They had a – they class school as home, family.

Now a lot of these kids, say myself, didn't have family support at home, so when we went to school, that's where we got our support. But if we're not getting the support there, where do you think these kids are getting support?

PROF KING: Yes, can I just pick up on that point, because you know, one of the issues with intergenerational trauma, making sure that we have a trauma informed, proper trauma informed care system, is where – you know, the point in a person's life where the intervention occurs. So my understanding of a lot of what you've been talking about, even at school level, in a sense it's - - -

MS REES: I'm really big on trauma aware schools. Dr Judith Power, QUT here at Queensland. She's written a draft on trauma informed schools, and it is brilliant. I actually am aware of the schools, Baringa State School. I'm in talks with Sharon Boland, who's the deputy principle. Again, very passionate about ACEs and they have implemented their trauma framework into their school, and I've been up there and I swear I walked out, one word, "calm". I've never walked into a school environment.

PROF KING: Yes.

MS REES: Now there's a child with special needs, and teacher can see by his behaviour, his body language, that he's not coping.

PROF KING: Yes.

MS REES: So they could call, and they've got a support person that steps in. "Hey little one, do you want to come for a walk?" And they go for a walk with them and you know, help regulate their emotions. So you're getting to them before they escalate to the state where you're unable to, you know, deescalate their mood.

MR WHITEFORD: Okay, understand that, but can I – because there's two - - -

MS REES: Sorry, (indistinct).

MR WHITEFORD: No, no. No, no. There's two issues though that relate to that. The first is if the trauma or the source of the trauma relates to the home, the family, then I guess – is having trauma informed schools enough if - - -

MS REES: No.

MR WHITEFORD: - - - the family – okay, so that's – so I'd like you to follow up on that. So perhaps if you can follow up on that, yes.

MS REES: GPs are our first point of call.

MR WHITEFORD: Yes.

MS REES: Now we're all going to go see the GP. I did a screening of a documentary called "resilient" at Queensland State Government, I think two years ago we did that, and it was my GP, Dr Danny – Danny – I can't remember his name.

MR WHITEFORD: That's all right.

MS REES: And my GP, he attended.

MR WHITEFORD: Yes.

MS REES: Now he works at a very – in a low socio group area. A lot of drug addiction and you know, dysfunctional families and stuff. After viewing this documentary on resilience, which highlights ACEs and the work that they're doing over there with this work. He actually said that he will now view his patients in a different light.

MR WHITEFORD: Yes.

MS REES: It's not – you know. Yes. Again, we want a two generation approach. So if GPs are taking the data, collecting this ACEs data, then you've got a bigger picture to write policy.

MR WHITEFORD: Okay.

MS REES: Do you know what I mean?

MR WHITEFORD: Yes.

MS REES: And I've got a lot of examples on how this data doesn't – sorry, the questionnaire – does not hurt us, it helps us.

MR WHITEFORD: Yes.

MS REES: I know for myself when I found out, I'm tenser. Since the original study, obviously more studies have occurred. And they've now added in historical trauma, which if we're talking about our First Nations, and I think we need to in a big way, historical trauma, epigenetics, there's our hope. Epigenetics is you turn on, turn off gene. It's very – it shapes who we are. And these memories, they're now scientifically proven, get transferred throughout the generations. And I truly believe if we were to change the conversation with our First Nations, especially our Aboriginal and Torres Strait Islanders, to something positive, to celebrate something that they already know and remove shame and blame, we're going to get decent results.

MR WHITEFORD: Yes.

MS REES: Like I'm Maori. I'm Maori descendent. And it was my culture that I'll hang onto, a belief, I really believe has kept me alive all these years, knowing that I – someone mothered me, it was my nana, my Maori nana.

MR WHITEFORD: Yes.

MS REES: I don't remember her, but I just knew that there's someone out there like me.

MR WHITEFORD: Yes.

MS REES: And that was enough.

PROF KING: Okay. Again, just on where – so you mentioned the GPs. How much do we also need to come back to sort of perinatal, you know, family support, again sort of thinking about the intervention as much as possible so that their – the trauma cycle is able to be held to - - -

MS REES: You're mitigating the harm.

PROF KING: Yes.

MS REES: Yes. Anything to (indistinct) those supports, and I've heard a lot of – I've been listening to a lot of the hearings, and I've heard some really good things happen there. But we do know that if we educate parents about their own ACEs, it helps them understand their lives, motivates them to learn becoming healthy parents to prevent passing (indistinct) onto their own kids.

PROF KING: Yes.

MS REES: Again, that's what I would say. If I knew this information, you don't think - like I knew I wanted to break cycles of violence, sexual abuse, alcohol and drug abuse, I needed to break those cycles and I have done. But what I didn't know was my fears, that that is what I transfer onto my children but, again, with this knowledge, I'm able to help them.

PROF KING: Yes, all right. I think I've covered off on pretty much everything.

PROF WHITEFORD: Anything else, Bronwyn, you wanted to mention to us before we - -

PROF KING: We finish up.

PROF WHITEFORD: - - - finish up and thank you for your time?

MS REES: Well, we're talking about is CBT and I really want us to get a grip on the importance of your own science, epigenetics and body. You know, we carry our trauma in our bodies so why aren't we working with the body, incorporating that into school programs and knowing what stimulates the brain and what doesn't stimulate the brain (indistinct). Do you know what I mean?

PROF WHITEFORD: Yes.

PROF KING: Yes. Just as a matter of interest, from your perspective, I mean we know CBT's the wrong therapy trauma I mean it just doesn't work but it's not meant to work for trauma. So there's alternative therapies such as - one's called EMDR, I'm not a therapist so I'm not going to try and remember the others but - - -

MS REES: You know, NDR, (indistinct), yoga, dance, anything to do with movement. You're actually realigning your body. So people ask me, I just say, 'Mate, jump around'; yawn is another (indistinct words).

PROF KING: So it's those sort of, you know, mind, body-based therapies that you found are the ones that work or the ones that are useful?

MS REES: The ones that helped me, yes, definitely.

PROF KING: Okay.

MS REES: Just telling me to get over something doesn't work because I don't feel it.

PROF WHITEFORD: Yes, that doesn't work.

MS REES: Like, rationally, I know when I'm triggered. Like, as an example I was on Facebook and I shared a picture of one of my children's birthday. I put it up as a header; their dad found me. I've been in hiding for many years. He'd found me and sent a message. I quickly jumped up, ran around the house, locked every window and sat in a corner shaking. He was nowhere near me and yet, my body reacted to it.

PROF KING: Yes.

MS REES: I had my grandson with me the other day; now that was me then, this is me today. Yes, so Friday I had my grandson with me and he was unwell. He'd come up with a rash, I'd rung his mum because I'm a bit worried. She said, 'Go to a chemist,' I went to a doctor. They were there, so I went straight into the doctor, they said, yes, he needed to be

seen straight away. My anxieties kicked in and I'm now not coping. The receptionist had said to me, 'You've got to fill out this form.' That part of my brain has switched off, I'm now in survival brain. So all I'm seeing is lots of words and nothing's making sense and I said to the receptionist, 'I need help. I can't do this.'

And whilst holding my grandson - this is how this work helps you - I'm that body aware that I felt the energy of my grandson drain because he was now picking up on my energy, which was chaotic. I knew at that point I had to step back and this is what I mean. This is how we can help our children and I knew I had to step back. So I stepped back, I rang mum and I said, 'Mum, talk to reception about the paperwork,' which they did. I was able to walk with my grandson saying, 'It's okay, bub,' you know, and work with him. Within seconds, his energy levels picked up and he was okay. Turns out he was fine; we got the medication into him and we avoided anything that went wrong.

PROF KING: Yes.

MS REES: But that's an example of how quick we can become reactive. I think for me, it's about a better quality of life, this information, but if we can get to people at a younger age with neuroplasticity, our brains do want to heal, we can rewire their brain; inspire to rewire. Neurons that fire together, wire together and again, repeat, repeat, repeat. You cannot have this information without keep on doing it. So the final thing I want to say today is my aim is to get out there, educate every person and every organisation about ACEs Science 101, how people and organisations integrate healing and to trauma-informed practices (indistinct) their families, their organisation, system and the communities in which they live.

Secondly, to aggregate, gather data such as a number of (indistinct), the number of organisations that are becoming trauma-informed and the resulting outcome in organisations and sectors, such as (indistinct), less absenteeism and less teacher turnover in schools as an example. Engage; engaging with people and organisations to join the local ACEs initiative. Little bit or a lot; any involvement is good; and fourth, to activate people and organisations to commit to integrating trauma-informed and resilience building practices in their personal, family, volunteer work and community lives. This heals systems and community.

And not to forget and celebrate any accomplishment ACEs summit, Community Resilience Day, Proclamation, post anything large or small that your community is doing on our website or hopefully the partnership that we're going to be setting up with ACEs Connection in America.

I know a lot of what you're discussing is really yucky and horrible, but once you start celebrating neuroscience and the hope with the resilience building work people, especially us parents, we want this information and it's amazing what we the people can do with it. But we can't do anything because we don't know about it. So expecting us to change isn't going to happen. We need this information and I'm hoping this report will (indistinct).

PROF KING: All right. Thank you so much, Bronwyn. That's been fantastic, so thank you for talking with us today.

MS REES: I'm happy to send through some information.

PROF WHITEFORD: Yes, please.

PROF KING: Thank you, Bronwyn. Thanks for doing on a day that probably wasn't your best day. So we really appreciate you being able to do that.

MS REES: Thank you. I just wanted to be heard, and I'm sorry, after what I've been listening to - yes, another thing. I've heard a lot of people worry about money. You've got counsellors wanting wages and TED support and I'm like, 'This is crazy.' There are so many services out there that I'm really afraid of because I know what they're doing and the ACEs work especially, and trauma and (indistinct) work, if not done properly, it can cause more harm than do good.

PROF KING: Yes, okay.

MS REES: And I will be watching like a hawk because I'm very passionate in this place and I'm not going to go quiet because, I don't know, it's lifesaving (indistinct).

PROF KING: All right, thanks, Bronwyn.

PROF WHITEFORD: Thanks, Bronwyn.

MS REES: You're welcome, thank you.

PROF KING: Bye.

MS REES: Bye-bye.

PROF KING: Jenny. Thank you, Jenny, brilliant.

MS SMITH: Yes.

PROF KING: And for the transcript, Jenny, you can just state your name, the organisation you're representing and any opening comments you'd like to make.

MS SMITH: Yes, thank you very much. I'm Jenny Smith. I coordinate the mental health programs for Anglicare throughout Central Queensland in the central west. I would like to start by saying thank you for coming to our regional areas. Very much appreciated, as well as all the information that's included in the reports, I think your presence here speaks louder than a whole lot of other things; so I would like to say thank you.

Just to give a little bit of my own stuff, I've been working in rural and remote communities and across Central Queensland - I've actually travelled from Spring shore this morning. So I work in those communities because I believe that rural communities need a voice.

So I have three areas that I would really like to really emphasise to the Commission and regarding the report. One, is don't underrate the importance of community non-government

services in the mental health system. Often the non-govt services, the community services are the services that are consistent, particularly in rural and remote areas.

Those services have been around along time, whereas some of our clinical services are constantly changing staff, constantly changing practices and the community services do a great job, and I know, speaking for not only Anglicare, but my other colleagues in other non-govt services, they work really, really hard and are passionate about supporting people with mental health. So that's one thing I just wanted to say around that.

One thing for people that we've discovered - so I've worked in this journey now for 20 years. I've worked with people with mental health for 20 years. The first I guess 10 of that was clearly around being a clinician and providing services and supporting people. I've endeavoured in the last 10 years to get into this wonderful space called the recovery space and for me, the journey for people with mental illness, travels from that intense space, building on their strengths, into being able to join groups and that has been phenomenal. Groups, inclusion, social inclusion, building their life skills, building their psychosocial skills, having the psychoeducational groups, have made an enormous difference and we have a variety of those groups that we offer including - and just listening to the lady Bronwyn in the previous conversation, very much about that sensory development to help with trauma-inform.

The emotion release in a safe way, in a safe space and some of the groups we find work really well, from our point of view, are the creative expression. Just people being able to release those emotions. Obviously the normal skill groups like cooking, budgeting, personal care, they're very, very important. But the one that I would really like to emphasise that we've travelled in the space over the last three years is DBT, and we recognised as an organisation, that there are a lot of people falling through the gaps in our services, in Central Queensland and in the west.

And in terms of falling through the services, I'm talking about primarily I guess people who have substance abuse or comorbidities around that or dual diagnosis around that and use substances as a way to self-medicate. And also, in addition to that, people who fall into the diagnostic categories of personality disorders.

So because there are limited resources in our areas, and the resources are changing, we were finding there were a whole group of people that were burning out services; they were burning bridges because - - -

PROF WHITEFORD: So the clients were burning out or the staff were burning out?

MS SMITH: Both, really, because the clients were having a voice: 'I want you to hear me, you're not hearing me. You're not giving me what I need to move forward.' You know, people in crisis, and particularly around personality disorders in crisis, can be very, very demanding and that's no disrespect. It speaks of the trauma that they've experienced.

So we got ourselves trained in DBT and have since, we've had approximately 120 people over the last three years in a very small service that have engaged in this DBT skill building - we don't call it therapy, we call it skill building.

PROF KING: Yes.

MS SMITH: And the results have been phenomenal. There's 80-odd per cent of people that have expressed feeling better about the world and it's the information and skills that they learn. Because, obviously, CBT is one of the preferred - I've lost my train of thought there. CBT is one of the things that's offered.

PROF KING: Yes.

MS SMITH: So when we offered DBT, just as an example just to highlight what I'm trying to say, I did some evaluation with the people, I did a (indistinct) with the people and I said, 'Was this successful? Is it worth us pursuing this?' - this is in the earlier days - and the young woman who was 25 said to me, 'I have been having CBT since I was 13 and I knew I had to change. But what DBT has taught me is the skills to use to change behaviours.'

So we built on that and unfortunately we don't have the resources to do really robust evaluations, and I would love to do that. But the feedback from people is they've engaged in employment, they've engaged in - and these are people that have been in the system for very long periods - they've engaged in employment, they've engaged in establishing relationships, they've engaged in education, their spark for wanting more information has been lit and they've continued on, and a very high thing, is we've been able to keep people from repeat hospitalisation.

PROF WHITEFORD: Can I just ask a quick question before I lose the train of thought? How long did it take you to train the staff in the DBT?

MS SMITH: We were already working in it but we got a trainer up and it was - I already have skilled staff in mental health.

PROF KING: Right.

MS SMITH: So we got this trainer up for a week to really work to further develop that training, some of our staff actually engaged in a year long training process through Sydney.

PROF KING: When you say, 'Trained staff,' so would they have psychology backgrounds? Would they have nursing background? What sort of training are we talking?

MS SMITH: We have some with psychology backgrounds, a number with social work backgrounds, a number who are lived experience peer workers who have engaged in formal education.

PROF KING: Yes.

MS SMITH: We have people who are teachers, we have people who are nurses and we have people on the road to learning. We have people who have worked in the industry for 20 years and have a real handle on mental health.

PROF KING: Sorry, I will let you finish your opening comments in a second, but we've taken a slight detour. One of the things that - and I'm not a clinician, I'm not psychologist, you know, I'm not an economist who's coming from outside.

MS SMITH: No.

PROF KING: One of the things that sort of strikes me in this area is there are a range of therapies and that work for different issues. So CBT fine for I think it's mild depression; it's really good.

MS SMITH: And anxiety.

PROF KING: And anxiety. DBT is more aimed at personality disorders; EMDR, which I mentioned earlier on, is very much for trauma.

MS SMITH: Trauma.

PROF KING: To what degree do you need - okay, so let me step back. You mentioned - CBT's come up a few times and it seems like - well, someone overseas is going, 'Let's train everyone up to do CBT and basic CBT'

MS SMITH: And low intensity CBT.

PROF KING: Yes, but as an outsider coming in, it sort of strikes me what we actually need is a workforce who either there's somebody there who's able to say, 'Well, you need this sort of therapy or this is the direction.' Or you need people who are able to deliver the right sort of therapy to the right person because - so when you say you trained up the workforce to DBT that sort of sends the alarm bells ringing because I think, well, what happens if someone comes to use your service where it isn't there?

MS SMITH: That isn't the only - - -

PROF KING: So can you try and clarify it ?

MS SMITH: Sorry, that isn't the only thing.

PROF KING: Yes.

MS SMITH: So when a person comes in - perhaps, I better just highlight the journey - shall I highlight the journey?

PROF KING: Yes, please, that'd be fantastic.

MS SMITH: I want to say, between 85 and 92 per cent of an outcome for a person entering the service is their engagement with their worker and, to us, that's crucial.

PROF KING: Yes.

MS SMITH: So a person comes in; they're referred into the service or whichever way the referral pathway is, it isn't about, 'You'll do this therapy,' it is about, 'Who are you? What is it you want? What is your experience? Can you talk to us about what are your strengths, where you're going?'

So there's a whole process around this and it's identifying people's strengths, working with people around (indistinct) domain and that's about sharing the conversations.

PROF KING: Yes.

MS SMITH: Having the conversations, finding out where they are. When they build a rapport, 'What are your goals in life?'

PROF KING: Yes.

MS SMITH: 'What is your vision for you? What is your vision?' If I saw you as someone who has incredible sense of wellbeing, emotional, physical, psychological, spiritual, 'What would I see that I'm not seeing now?'

PROF KING: Yes.

MS SMITH: And it's about that conversation goes. People's goals are highlighted and then those therapies are offered as an option.

PROF KING: Okay.

MS SMITH: 'Would you like to explore this?' or you work with someone for three months to get them in a safe space. You don't give any therapy when people first enter because generally they're in a crisis state. They're not ready to hear anything, so you (indistinct) capacity within the service, within themselves to be able to be open to receiving therapies.

PROF KING: Yes.

MS SMITH: And I think that's a mistake that we make, and I would say - probably I'm talking out of school here - - -

PROF KING: No.

MS SMITH: But in terms of have better access in our psychological therapies and this, I think it's a huge mistake because the first port of call is let's put them into a psychologist. You're wasting the person's time and another sense of failure because they're not able to engage in that therapy.

PROF KING: Yes.

MS SMITH: Does that make sense?

PROF KING: Yes; no, it does.

MS SMITH: Yes, so it is about there's a time for more intense therapy, but it isn't as the first port of call, even if you can get (indistinct) in your report you say, 'there's lots of psychologists in Australia,' I'd like to invite them into the rural areas if they would like to come; we would look after them.

PROF KING: There is a mill distribution; Melbourne, Sydney corridor and Brisbane. Lots of psychologists but, yes, not elsewhere.

MS SMITH: We're fighting all the time for psychologists. 'Please, come, we're very nice people.'

PROF KING: Anyway, we're in the right (indistinct).

MS SMITH: Yes, so in terms of that, our journey with people isn't about what we think or we assess as being what they need or what they want, it's what they identify as ambition for wellbeing.

PROF KING: Okay, sorry, now, we interrupted your opening comments (indistinct).

MS SMITH: No, that's okay.

PROF WHITEFORD: Anything else?

MS SMITH: Yes, so (indistinct) you know, you can work with someone on an individual basis, but when they feel safe enough and ready enough to join in a group. That's when you see recovery (indistinct).

PROF KING: And social inclusion.

MS SMITH: And social inclusion.

PROF WHITEFORD: So what are the pathways into social inclusion, do you think? So what do you know just from the services you get involved in that work to get these people back into - not I guess into mainstream, but into pathways that work for them rather than just the pathways that, you know, everybody knows about or whatever.

MS SMITH: In my grey-headed experience the first thing is to get them feeling safe and a little bit confident in themselves. When you do that, and I suppose in that is that trust building in the service relationship, and then we're asking people to get a little bit out of their comfort zone. Let's try the group stuff and peer workforce are amazing in helping people move forward with that one.

PROF KING: (Indistinct).

MS SMITH: They're just amazing in giving people the confidence to give it a go and then, once you get them into the groups, social inclusion first; they start to meet other people. And just as an example of that, I had one woman, personal disorder, really, really, in the systems

for many years, and I said to her, 'Could you just try this group?' She went and she come sobbing and I thought, 'Geez, I made the wrong mistake there.' But what it turned out, that was the first time in her life she'd met someone that had the same thing. So for her, that was a new experience and she's gone on to bigger and better things now.

PROF KING: Yes.

MS SMITH: And social inclusion is trying to reconnect with family members that have been disengaged because of the illness and try and connect with those support networks and mediate those support networks to, you know, educate the people in those support networks to be able to then support people and, yes, people do come into the mainstream as well, when they feel safe enough.

PROF KING: So say, somebody with a borderline personality disorder probably not employed, maybe having trouble maintaining housing. We've talked a lot about, in a sense, the community/quossie clinical side, if I can call it that. But do we really need a team support around that individual because there's a whole bunch of other things happening in their lives as well. How does somebody like them (indistinct)?

MS SMITH: Often people become overwhelmed with a whole lot of people in their lives and I think that's where we try to coordinate that and work with them to see with they're at, so they're not overwhelmed, that we can navigate when it's a safe time for them to navigate.

PROF KING: Okay, yes.

MS SMITH: Yes, but generally, you know, you do need a number of people around. You need that clinical for the suicidal times and that's why it's really important for us to have a close relationship with our clinical colleagues to be able to, in times when it's beyond the capacity of community, to handle this is to work with the colleagues.

PROF KING: Because we did emphasise in our report importance of that team-based care.

MS SMITH: Absolutely. PIR was a wonderful example.

PROF KING: Yes.

MS SMITH: PIR was a great example of coordination and being able to - because the support facilitators were the constant in that person's life and the outcomes change when you get everyone on the same page at the same table.

PROF KING: And truly having that constant. I mean we've been accused of reinventing PIR which is sort of true.

MS SMITH: No, well, you agree with me. But I mean whatever you call it that is certainly I think is that coordination.

PROF KING: The key or a key element, yes.

MS SMITH: But even with PIR, because we had a few facilitators in PIR, we didn't know enough about coordination. We didn't get enough of the substance of coordination. We've learnt more as NDIS has come in about coordination so we'd get people sitting at the same table. But I think we've build a lot of skills around coordination now.

PROF KING: So what are the extra skills you think are being built?

MS SMITH: I think a lot of it with PIR - and you'll know this at the beginning - a lot of it at PIR it was seen as, 'We need services. We don't need anyone to coordinate us,' so there wasn't that respect.

PROF KING: Okay.

MS SMITH: So for the first three years of PIR it was people feeling confident within their own practice to be able to say, 'Well, no, Dr Such and such, this is what we're seeing. I'm wondering if you can come with us and help us achieve this for Jenny.' You know, so that's what we see with - that's why I think it's phenomenal.

PROF KING: Yes.

PROF WHITEFORD: So the skills we've got is confidence, more knowledge about, you know, coordinating supports and more traction in the space, more validation in the space.

PROF KING: Yes, okay, are there barriers to the involvement of consumers in carers that we could, you know, consider; we could make recommendations?

MS SMITH: Absolutely.

PROF WHITEFORD: Well, what would change to make that involvement, you know, better from your perspective?

MS SMITH: Constantly have carers talking, well, through our processes we - in one of our previous things, carers were one of our groups that we worked with. Unfortunately they've been left out in the cold with it now, but carers, they feel the system lets them down; they're not heard, that collateral information isn't taken seriously enough.

PROF WHITEFORD: Yes.

MS SMITH: So I have two workers that have people who are - and they're both social workers - and ones a social worker and ones a triple degree psychology social worker. Now, they both have children who are, perhaps, severe and persistent mental illness. Now, they say it doesn't matter that they work in the industry and that they're degreed in this; they're not listened to.

PROF WHITEFORD: Yes.

MS SMITH: So systems will, if the person's in the in-patient unit, they're training the people in the in-patient units how to manage their person.

PROF WHITEFORD: Sorry, so can I just clarify and make sure I understood what you've just said. So those individuals are training the clinicians who work in the in-patient units, so they're coming from the perspective of carers.

MS SMITH: Yes, and who know that person; who know that.

PROF WHITEFORD: Okay.

MS SMITH: So if someone's tearing their hair and feared, 'Oh, he thinks he's got spiders in his hair.' 'Oh, has he?' but at times - - -

PROF WHITEFORD: Sorry, when you say, 'Training,' you do mean formally training or just - - -

MS SMITH: No, no, I meant - - -

PROF WHITEFORD: Yes, just to clarify.

MS SMITH: Informally giving information that will support that person's care whilst in the in-patient unit.

PROF WHITEFORD: Informally in their role of carers, yes. But is it recognised the service?

MS SMITH: No.

PROF WHITEFORD: So part of what we do is bring carers in to help our staff understand.

MS SMITH: Beautiful; that would be really positive, but just let them - - -

PROF WHITEFORD: Right.

MS SMITH: And we know there's sometimes carers who are overprotective; we know that. But surely as professionals, we can manage that and bring them with us. But there's a lot of times, and I think one of the carers said to me, 'I don't know where to go next. I have just got my son to talk with the psychiatrist and he said, "Well, you know terrorists are a problem."' So for them, it is. We've got a long way to go culturally, but it's exciting that we're at the beginning of the journey in that way I think.

PROF WHITEFORD: Yes, okay.

MS SMITH: Carers are people; they're an invaluable resource.

PROF WHITEFORD: Yes.

MS SMITH: So, you know, like, for example one of the sons of one of the women that I'm working with, tomorrow is giving a talk to staff by digital stuff to help us understand the

space and what we need to be mindful of. High functioning, (indistinct) international business man.

PROF KING: Just one final question from me. You mentioned peer workers before, and we've got some recommendations about, you know, representative organisations for peer workers, helping them, you know, get a part because sometimes peer workers are viewed, well, they're an untrained voluntary workforce, and we want to move away from that because they're a lot more valuable than that.

MS SMITH: Yes, absolutely.

PROF KING: But have you had any suggestions on how we can do - - -

MS SMITH: I have. I've just dipped my toe into this in the last two years, to be honest, and I did it with great trepidation.

PROF KING: Yes.

MS SMITH: Not because I don't think - I know the value, but I was making sure that our organisation could support these people and that's one of the things. So we've just employed a further six peer workers in our organisation, so about 20 staff for mental health in our organisation. I think it's 11 are lived experience.

PROF KING: Yes.

MS SMITH: And the recommendations I would make is help us do the right job. Help us not go down previous historical paths where we devalue people or we're not inclusive enough of the experience. What are the support needs that may be different for peer workers? You know, workers that identify as being well emotionally.

PROF KING: Yes.

MS SMITH: Because we don't call the peer workers, we call them living experience workers because they're still living every day with their mental illness, even though they're functioning beautifully.

PROF KING: Yes.

MS SMITH: So the recommendation is help us; help us do it right. Give us - you know, like, you've got the ability to do all of the research and we've just engaged in the Queensland Mental Health Commission of Peer Support Framework.

PROF KING: Yes.

MS SMITH: So we're using that as a guiding document. But it's great in the strategic level, but it's not great in details.

PROF KING: Yes.

MS SMITH: What do we need to be careful of? So I've engaged with other peer-led organisations to help. So if you as a commission and in a position where you can really influence - and you are obviously - but influences; help organisations do the right thing by the people (indistinct) I think, yes.

PROF KING: Okay.

MS SMITH: So we need education for organisations.

PROF KING: Yes.

MS SMITH: And for me, I'm still flying a bit blind here, with good intent, but I want that good intent to be okay and safe.

PROF KING: Okay.

MS SMITH: And that is, how do I help my organisation engage in that.

PROF KING: All right, thank you.

MS SMITH: And detailed guidelines around that would be - - -

PROF KING: Yes.

MS SMITH: Is that enough?

PROF KING: Yes.

PROF WHITEFORD: We understand. So that's all?

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

MS SMITH: Thank you. I just wanted to say, I know NDIS isn't part of this, but in rural areas it is the best rural, you know, social reform of our era. It is just fantastic, but we've still got a way to go with mental health; you know that.

PROF WHITEFORD: Indeed.

PROF KING: Yes.

MS SMITH: Because people with mental health that we've help transition through PIR are now wanting to re-engage with us because their mental health is deteriorating because their support workers aren't being trained.

PROF WHITEFORD: Yes.

MS SMITH: Thank you.

PROF KING: Thank you to you.

MS SMITH: I really appreciate your time.

PROF KING: No, thank you, Jenny. That's been fantastic. Belinda, so, please, come and sit.

MS CHELIUS: Yes.

PROF KING: If you could state your name, organisation you represent and any opening comments that you'd like to make for us, Belinda.

MS CHELIUS: My name is Belinda Chelius. I'm the General Manager for Eating Disorders Queensland. So we are a state-wide funded service by Queensland Health. So there's a hope that we do state-wide delivery but of course, the bucket of money doesn't extend completely state-wide, but we do aim.

So my conversation would've been a little bit around rural and remote support and I'm not going to speak about a specialist field, but prior to being the general manager, I worked in other NGOs across mental health and of course, PIR, I've got extensive experience in running it and been overseeing PIR and that was probably my opening statement that I wanted to make because the report talks about care coordination. We invested a lot of money in Partners in Recovery. I think it was the biggest expenditure yet, that Australia did.

Why? Why has it gone? It worked exceptionally well, especially in the PHNs that I had the privilege of working with, which is Brisbane North, exceptional consortia, exceptional ways of working together. The training, the systems reform that came out of that on grass root levels, not just the higher systemic reforms because they had a little bit of brokerage money for systems reform.

And, you know, even having brokerage money, we found we didn't use a lot of that money. We could do a lot with a little bit of money and getting not to present at hospitals. I know that's just my biggest surprise, that PIR and all that amazing resources, that resort, the data we collected through PIR, it's like a wealth. Where's it gone? Why did we waste that money? That, to me, is just unfathomable.

PROF KING: Can I just ask a follow up question on that?

MS CHELIUS: Yes.

PROF KING: So we understood that the money that was for PIR went to NDIS.

MS CHELIUS: Yes; NDIS.

PROF KING: Yes, but the PHNs were then given money to replace some of that work.

MS CHELIUS: Yes, but it was not the same level.

PROF KING: Okay.

MS CHELIUS: So what PIR now - I'm not involved with PIR anymore, but I know purely, they were transitioning people into NDIS.

PROF KING: Right.

MS CHELIUS: So what that meant, it's psychosocial support, but people with mental health concerns, we know they aren't always eligible for NDIS so it's a small percentage of that clientele that get into NDIS so what happened to the others that aren't eligible for NDIS? So we know the PHaMs program also was absorbed into NDIS. There needs to be a rejig of that because people keep talking about care coordination and I'm, like, 'Hello, we've done it. We've done a lot of it. We've got lots of research. Why do we do the same things'. I'm just a little bit - unless I don't have the bigger picture but I've worked around this track - - -

PROF KING: No, I don't think you're the only one. We've had - just every public hearing just to that we've been told the same story.

MS CHELIUS: Yes. Okay, great. Because I worked initially in setting it up and I oversaw quite a few PIRs across PHNs and it works. Mike Butler had a great idea at work, like, - - -

PROF KING: Can I just before we - - -

MS CHELIUS: Before we get into eating disorders.

PROF KING: Get into eating disorders, yes. Can I just ask why do you think - what was the key for PIR working as well it did? What were the core elements? If you were saying, 'Look, yes, we could do it again. These are the three things you need to make sure you have to get the benefits that we got out of PIR'; what would they be? What are the core elements?

MS CHELIUS: Work has been bettered in organisations that worked with clients who already trusted them.

PROF KING: Yes.

MS CHELIUS: They weren't an extension of HHS or the emergency departments, there was initially - obviously when everyone went for the funding there was a competitive - because we know that tendering makes us all competitive and put us against each other - and then we coped well together; but that's fine. With PIR, once we had the funding it created a collaboration. My organisation didn't do AOD and I knew that, organisationed it, referral pathways.

PROF KING: Yes.

MS CHELIUS: We actually got to know who the services were. Just like the clients who struggle navigating the system so do the workers so we actually started to get to know each other, where do send people, so that was really, really, important and having a good PHN.

Having a PHN that's involved, that gives resources, training, that was the core and I worked across a few PHNs and Brisbane North was by far an outstanding of how we work together and the organisations that tendered and got part of the consortia but it was very good with PHN Brisbane, and the staff.

There was a new way for innovation so we found out that the LGBTI community needed a PIR worker so we could give up some on your positions (indistinct words) get a worker and the same with RYUI, an indigenous organisation, they did it. PIR, so some of the big consortia members gave up FTE to give to other organisations so there was a bit of inflexibility in that whole tendering process.

PROF KING: Yes. Eating disorders.

MS CHELIUS: Eating disorders, the passion where I'm - why I'm here. It's like I say we're state wide service so rural and remote areas, it's an issue for us.

PROF KING: Yes.

MS CHELIUS: Queensland Health acknowledges that but of course it's the bucket of money and it's state funding versus federal funding so that's that gap again. If you've got state funding, the feds are not going to look at you - just because you've got a big overall and remote area that you've got to cover so we do look at Telehealth but I think there needs to be a better government approach - support for NGOs at around Telehealth so right now I will purchase Zoom, do Zoom with clients in regional remote areas but I think we need something a little bit more sophisticated and Telehealth, there's the Telehealth platform but Queensland hasn't signed up to that one so again some states sign up to some things, some states don't, so.

PROF KING: Do you find the Telehealth effective?

MS CHELIUS: Yes, so especially for disorders because it's such a specialist field and a lot of your - even in urban areas your clinicians are reluctant to go there so we find for our cohort we would like to see something of them initially because there's a big medical crisis attached to that but obviously it's not always possible but for us it does work.

PROF KING: Yes.

MS CHELIUS: Yes, it does. It's not the same. Because our organisation offers so much more than just the one on one, you know, recovery is not just (indistinct words), it's about relationships, it's about communities, it's about engagement so as rural and remote is a real struggle.

PROF KING: Yes.

MS CHELIUS: And like I said it's not like Queensland Health doesn't know that but it's hard - and we also find for us as an organisation based on Brisbane, to come into rural remotes areas sometimes I could get a grant, for example, to do groups in Toowoomba but because the community doesn't know us we found it a real struggle to actually get people to engage with us.

PROF KING: Okay.

MS CHELIUS: Because we're not local.

PROF KING: Yes.

MS CHELIUS: They don't know us. 'Who are you? Where are you from?'

PROF KING: So both the clinical and the community based - - -

MS CHELIUS: Yes, yes, so I would go to HHS and they said, 'We've got a lot of patients, inpatient', we can get them' - okay, eating disorders is something anyone wants to admit to but we just find - yes, we just don't have the capacity to be on the ground all the time because the communities trust who they have in their communities so our best way of getting in to communities were through the schools. They were very, very, very successful, exceptionally successful.

PROF KING: Okay. What do you do in this course?

MS CHELIUS: So do early intervention prevention, we don't talk eating disorders in schools, we go in and educate around weight stigma, diet culture, social media, media literacy and we try and pre-empt a lot of cultures that live in an eating disorder especially how people are perceived; how you should look, what you should wear, and also the - and unfortunately that still happens in school education, there's a morality around good and bad foods, there's - you know, if you look a certain way you're successful and it's the diet culture so that's what we do in schools is actually going in and giving young people and the school-based nurses or the counsellors at the school a different language to use around food and around health. Health is not just about clean eating and not eating sugar.

PROF KING: So is the program to the students or to the teachers?

MS CHELIUS: So the teachers usually come to us and ask us to come into the schools but I think the way we've designed it it actually touches across all of them. The teachers will come and say, 'We've learnt from that' so we're just working with QUT now to get it really embedded and evaluated and rolling out and creating a bit of that peer mentoring and you've mentioned that in the report. You're not choosing leaders in the schools.

PROF KING: Yes.

MS CHELIUS: And Butterfly Foundation has done that too and it works really, really well and I think that's how we can get into remote and rural communities to start trusting us, this is the school-based ones. Once you're in a full blown eating disorder my feeling is it's a different approach, it's different.

PROF KING: Well, how well do the GPs play their role of recognising eating disorders, knowing what services are needed for the person; so are GPs effective or not?

MS CHELIUS: It's a hard one. Yes, so in Brisbane we've got I can count on one hand the GPs we use. We are main NGO funded by Queensland Health so most of the people - it's a step down approach; come from hospital, go through to (indistinct words), comes to us. A handful who feels comfortable working with people with eating disorders. We have a lot of stigma attached to that and I think we put a lot of burden on RGPs, our general practitioners, and notes all about going to your GP. I think RGPs have got 15-30 appointments.

PROF KING: Yes.

MS CHELIUS: There's a lot of assessment to be done when somebody presents with a possible eating disorders. And history, it's metabolic rates, it's all of that stuff so we've created a lot of resources for GPs and NEDC is really good, that's from Butterfly Foundation, to help educate but I think they struggle and they scare because it's got the highest mortality rate of any mental health concern so it's hard, there's a huge burden on RGPs.

PROF KING: So one of the things that you said sort of worry me. You said - and I want to make sure I got it right - mainly your services are step down so it sounds like, you know, even if they are seeing GPs or whoever, for generally young people, end up in hospital and it's only then that they start getting the relevant - - -

MS CHELIUS: Yes, unfortunately.

PROF KING: - - - you know, the specific services that they need for the eating disorder whereas if the GPs and the other (indistinct) pathways were effective I would have thought you'd see step up so - - -

MS CHELIUS: Hope so, yes.

PROF KING: So you just don't see any step up at the moment?

MS CHELIUS: Not yet, not yet. I think we're getting there so obviously with an eating disorder if you're in a full blown eating disorder, minimum seven years recovery and that's very conservative and we know they drop significantly with early intervention in the first two years and that cuts the cost - you know, if you look at the economic cost of an eating disorder, even if we look at productivity so - - -

PROF KING: So you've mentioned schools. Is schools really the main way to get that early intervention?

MS CHELIUS: I reckon schools are really, really important because it takes away from the stigma and especially in young, young males and I'll marginalise communities so it will be LGBTI communities, our indigenous communities. Indigenous communities now list body issues as number two according to the last survey done by - a very common survey, I've forgotten the name. It's Mission, It's Mission Australia does the surveys. So it's our marginalised communities too that have got high rates of eating disorders that are underreported and I picked up in the report about psychological therapies. It's more economical per session in block funded services.

Okay, so I actually don't understand that driver because a block funded service gives you more than just the one on one session, the block funded services gives you the group therapy, the meal support, the social connection, the carer support, integration back into community so - I'm not a mathematician, I'm a social worker - - -

PROF KING: Before I pass over to Harvey, because there's a couple of things I want to follow-up. Your school program, I think you said it hadn't yet been evaluated, you're working with?

MS CHELIUS: Queensland University.

PROF KING: QUT?

MS CHELIUS: QUT, yes.

PROF KING: Yes, okay.

MS CHELIUS: But we're doing it already and we actually have done it previously and it was called the 'I Love Me' project and it's very much peer-based run in the school with school leaders and that actually won an award, it was really so well received that we ran out of funds, so.

PROF KING: So was that actually formally evaluated?

MS CHELIUS: Yes, yes.

PROF KING: Okay, and - - -

MS CHELIUS: There were significant clinical outcomes, statistically I think the numbers were a bit too small.

PROF KING: Okay, so if we Google, 'I Love Me evaluation' - - -

MS CHELIUS: Yes, I could send - - -

PROF KING: If you could it send through, yes, okay.

MS CHELIUS: Yes, I can send that through to you, yes.

PROF KING: Just on gateways in step up, we've discussed about GPs. headspace, do you have interaction with headspace? Does it work as a doorway or a gateway for young people with eating disorders?

MS CHELIUS: We work closely with headspace, they sent them to us.

PROF KING: Okay, yes.

MS CHELIUS: So in the Brisbane big metropolitan area they either go through - they've been at RBH because there's five beds, they tend to step down into QuEDS, that is the day program, they can only take eight people at a time and then it comes through to us but a lot of it they'll self-refer into our service which they can. There is CYMHS who do the FBT which is a family-based therapy, doesn't work for everyone, it just does not work for everyone.

So because we've got that very eclectic approach, it's trauma informed with your DBT, with your acceptance commitment, with your CBT and we tend to say, 'What works for you?' and we create a therapy that suits the client.

PROF KING: Yes, just to come back to headspace, so you said they refer to you. So would that be people who are going to headspace, they haven't been hospitalised? I'm just again trying to work out do they have any effective step ups at the moment going?

MS CHELIUS: The step up for us would probably be us, (Indistinct words) Queensland. Yes, headspace but minimal practitioners that feel comfortable. I think that Taringa one we feel a little bit more comfortable working with eating disorders. I think we're still sitting in a space where it's crisis. My child is now underweight and there's significant physical harm and then we'll go to the GP because I can see they're losing weight where we know an eating disorder is dangerous 'before' we see the weight loss.

PROF KING: Yes.

MS CHELIUS: So I think there's still very much that gap between 'let's catch it' before.

PROF KING: Okay, you mention Brisbane, outside, rural and regional areas.

MS CHELIUS: Goodness, no, there's like - it's scary. Like, it's a rocky hospital that really tries but there's - so they just don't have - I know QuEDS try and do train, they also do state wide training for eating disorders but it's minimal. I think they might have one psychiatrist who will have an interest and they work across mental health so in my view, in my experience, and my colleagues would agree, it's a specialist field. You need specialist training, GPs, psychiatrists, who know the physical symptoms before they become evidence so, yes, a step up approach is - yes, at the moment we've got very much a step care approach, yes.

MR WHITEFORD: Okay. One more question before we finish. So just going back to work in schools.

MS CHELIUS: Yes.

MR WHITEFORD: So one of the things we've heard is, (1) that's a very important place to intervene; secondly, that the school curriculum is overloaded and there's not enough space to do pretty much anything else.

MS CHELIUS: Correct.

MR WHITEFORD: And that there is the - what used to be 'Mind Matters' now 'Be You' from Beyond Blue; so how would - what you do in schools fit into that, is it separate to the - something like 'Be You' or has it tried to be integrated or does that - - -

MS CHELIUS: It could probably work, some are integrated, but we focus specifically around eating, body image, social and cultural influences, so it's not - again it's not a generalist approach, we go in and we target that particular message around a culture around food about how you judge and what you look like because not everyone who diet gets an eating disorder but most people with eating disorders have dieted so it's a diet culture and obviously a very strong trauma informed mental illness.

PROF KING: Okay. And just on your block funded bit. It's not block funded services 'in generally', it's block funded so if you have a clinician who is receiving their remuneration through a block fund, so if we know there's a whole other bunch of stuff, they - well, some of the numbers are well below - (indistinct words) thing clients are well below what you would - - -

MS CHELIUS: So you're not talking NGO block funding?

PROF KING: No, no, no, it's that particular - you know, in other words if you're a clinical, how do the incentives change your behaviour to be able to see clients versus spend your day filling out paperwork or whatever else is happening so, yes, and some things are better block funded so - - -

MS CHELIUS: So just on suicide prevention eating disorders got 30 times more likely people to die by suicide. In Brisbane they are busy doing safe spaces that's connected to the emergency departments, I think that really needs to be reviewed. You cannot have a safe space attached to an ED for people that are as vulnerable as people with eating disorders. It's just it needs to be embedded - a safe space for prevention of suicide needs to be embedded in the existing resources like an NGO where they feel safe and supported.

PROF KING: Hang on, I'm going to follow up on that.

MS CHELIUS: I'm a bit worried about that.

PROF KING: So let's take something like the Safe Haven Café, it - - -

MS CHELIUS: Yes.

PROF KING: And one of the ones in Melbourne, St Vincent's is it?

MS CHELIUS: It is St Vincent's, yes, and they've got a good model but I don't think they attach to the - are they attached to the emergency department?

PROF KING: They're certain closely connected to the emergency but physically they're separate so you don't go through the emergency department door because they're physically separate but the idea there is that it's open out of hours, the key thing is the out of hours because my immediate reaction when you said, 'Well, it's got to be through the NGO', it's got

to be an out of hours service because we know that's when the demand comes in the ED so do you mind clarifying what you actually mean by that; do you mean it can't be physically attached as in you don't go through the ED doors and then move off to the right or?

MS CHELIUS: And I think because it's going to be - my feeling on what I know is going to be run through HHSs so are we running just a replica of an emergency department which does not work for a very vulnerable group of people and - - -

PROF KING: So does not work means it's not safe or it's not therapeutic?

MS CHELIUS: Both. It's not safe, there's a stigma around people with eating disorders and personality disorders that present; why don't you just eat? Like, 'Why are you here?' Now I've got suicidal ideation. Well, you know, you can wait because I understand that somebody with psychosis presents more scary and needs more attention and I get that, I'm not at all stigmatising them, we can't combine the two so I think we need to think this through that everything was attached to a HHS because are we, my question is, creating just another extension of an emergency department or are we saying there's existing resources, yes, it's got to run after hours but how does that work with a vulnerable group, it's usually young women with major trauma, either sexual assault, historical sexual assault with an eating disorder and the same for young males that are transgender or LGBTI. You're putting them in an environment that's not safe, have got - there's always somebody that's more unwell.

PROF KING: But that wouldn't let us off the hook, I think, for trying to say that emergency services should be more sensitive to dealing with people with eating disorders.

MS CHELIUS: Yes, 100 per cent, 100 per cent, but if we're looking at safe spaces let's not create another model because I know there's this movement about less NGOs so that we can all deal with one big generalist service, that's very much a message we're getting - - -

PROF KING: From?

MS CHELIUS: From hospital health services, they don't want to deal with a million little NGOs, it's inconvenient. But you know why it's convenient for the client because they could choose so if we had one big generalist that's a whole other talking point for me, generalist approach. It doesn't work for mental health issues especially not for something like sexual assault, domestic violence, eating disorders, that's pertained to a very vulnerable cohort.

PROF KING: So - - -

MS CHELIUS: Yes, okay, I'll just - - -

PROF KING: You've gone down another track.

MS CHELIUS: Sorry.

PROF KING: So consumer choice - - -

MS CHELIUS: Consumer choice.

PROF KING: Consumer choice is important. We understand how consumer engagement is important in their own care and choice is part of that engagement because it empowers the consumer. But how do we make or how do we enable that when our clinical systems are very much, you know, not meaning this in a bad way, but it is, you know, and escalator. You know, you get on at the bottom and you get out at the top type of thing.

MS CHELIUS: Yes.

PROF KING: And so how do we make that or enable that consumer choice around a clinical system and then, how would we do it outside the urban areas?

MS CHELIUS: I think again, I come back to, in Brisbane, we had PIR in the hospitals. So you have that one constant care to - - -

PROF KING: So it's to navigate, okay.

MS CHELIUS: Care coordinator who says, 'Eating Disorders, these are the options, would you' - you know?

PROF KING: Okay, yes.

MS CHELIUS: So again, it's that one consistent and that's what PIR did really do well because I don't know if it happened everywhere, but we embedded it in the hospitals.

PROF KING: Yes.

MS CHELIUS: I think it's harder in rural and remote communities because there aren't as many services to navigate people to. So it's again, coming back to funding

PROF KING: Yes, okay, all good?

PROF WHITEFORD: All good.

PROF KING: Thank you very much for that.

PROF WHITEFORD: Thank you.

PROF KING: And then we were just warming up but it always gets me worried. I stop talking when - - -

PROF WHITEFORD: No, okay.

PROF KING: All right, Carol, you can come down. And so, Carol, if you're able to state your name, group that you represent and any opening comments that you'd like to make.

MS MARKIE-DADDS: Thank you. Good afternoon, I'm Carol Markie-Dadds. Can you hear me okay?

PROF KING: Yes, all good.

MS MARKIE-DADDS: I'm Carol Markie-Dadds and I'm the Country Director for Triple P International in Australia. Before we begin, I'd like to acknowledge and pay tribute to the Darambul people, the traditional owners of the land we are gathered on today, and pay my respects to the Elders past, present and emerging.

Thank you for the opportunity to speak today and for the extensive work and consultation that has gone into the draft report. For my opening remarks I'll highlight the critical role of a safe and stable parenting environment as a protective factor and determinant of a child's mental health and resilience over their life span. I'll also comment on a few general areas from the draft report pertaining to prevention and early intervention for mental ill health and workforce professional development before taking any specific questions you may have, particularly around implementation examples, system design, cost-effectiveness and outcomes of the program.

PROF KING: Thank you.

MS MARKIE-DADDS: The Triple P, Positive Parenting Program, is a University of Queensland developed system of parenting support interventions and, more recently, includes professional development for educators. It's one of the most effective evidence-based parenting programs in the world. Of all the factors of effecting a child's life, parenting has a critical and pervasive influence over the life course and Triple P's expertise is in promoting the mental health and resilience of children by increasing the confidence and competence of parents.

Triple P has proven effectiveness across a number of outcomes, including improving children's mental health and wellbeing, reducing the numbers of children in out-of-home care, improving educational results, improving children's relationship within and outside the family, supporting Indigenous families and reducing behaviours in young children shown to place them at a risk of lifetime offending. Additionally, we know that low intensity programs, as well as online programs, are effective in addressing childhood mental health problems and these delivery modalities are engaging vulnerable families.

Although I'm here, today, with my Triple P hat on, I speak to the general endorsement of rigorously evidence-based and cost-effective parenting supports as crucial to the transformation of Australia's mental wellbeing into the future.

I cannot stress enough the necessity of supporting parents, and by extension, their children, if we truly desire generational change and reduction in mental ill health and the other life challenges that mental ill health presents. The social determinants lands of the Commission's draft report is very welcome and the specific recommendations around social and emotional development and learning in early childhood in education settings, shows recognition of this critical time in a child's life.

In particular, Triple P International strongly endorses the recommendation to expand the purview of early childhood health checks, to include social and emotional development

before pre-school, the expansion of parent education programs and increased attention and quality control of professional development for early childhood educators.

We note the extensive literature around the implications of the first 1000 days of a child's life for broad outcomes across the lifespan. NSW Health has recently released a first 2000 days framework, which takes this concept further to comprehensively deal with the importance of school readiness and quality early childhood education for long-term outcomes.

Any reform work that targets the mental health and wellbeing of children must include consideration of the environments that children live in, which is one heavily influenced by interactions and relationships with their parents and educators. On this theme, p.650 of the draft report notably reads: 'The effects of reforms and other interventions will be short lived if those working with children and young people are not equipped with skill sets that enable them to continue to support better mental health and wellbeing in their ongoing work. Supporting children's mental health means also supporting those crucial people around them to avoid exacerbating any stressors and enable positive social, emotional and behavioural development.'

Educators as well, must have quality professional development that includes all competencies around confidence in consulting with parents of children in their care in regards to social, emotional and behavioural issues in development. There are obviously some challenges to the regulation and funding of professional development in the early childhood sector given the public private mix. But it's crucial this sector is acknowledged for the importance it can have over long-term outcomes for children's mental health and wellbeing.

In acknowledgement of this crucial role of earlier childhood educators, Triple P has begun to make available it's evidence-based professional development program Positive Early Childhood Education, with the knowledge that for every \$1 spent on quality early childhood education, an estimated 1 to 5 dollars is returned to the economy.

An RCT of this program resulted in significantly less disruptive child behaviour and self-reports from educators found they felt less stressed at work, communicated better with each other and supported each other, they felt more prepared and supported to meet complex needs and respond to child behaviour that they found challenging.

Importantly, educators said after the program completion, that they had a better understanding of their own personal capacity to bring about change in children's' behaviour and the value of collaborating with parents to support children.

We know that building resilience is a crucial protective factor against mental illness. Some key findings just released from the longitudinal survey of Australian children which has followed 10,000 children since 2003, found that resilience levels were higher among 16 and 17 year olds who had consistently close relationships with one or both parents and average resilience levels were lower for those 16 and 17 year olds who experienced conflict with their parents between the ages of 12 and 15 or who lacked family support between the ages of 10 and 13.

This goes to the need to support parents as crucial to children's mental health and wellbeing even as they get older and move into secondary education. Additionally, as with early childhood, workforces interacting with older children, educators, psychologists and the proposed wellbeing leaders, must have the capacity to hold meaningful and constructive consultation with parents and not treat children in isolation from their environment and immediate home and family contexts.

The cost-effectiveness of prevention and early intervention of parenting and early childhood support acknowledged in the draft report, can only be realised where implementation is carried out effectively, and we support the greater monitoring of outcomes suggested in the recommendations and more stringent requirements on evidence-based and prove cost-effectiveness of programs prior to their funding.

The Australian Early Development Census is a great data tool to assist population level to this end and could be utilised more comprehensively by funders. On the note of cost-effectiveness, independent modelling has shown that early investment in the Triple P system by governments generates a benefit between four and 12 times the original spend.

The recommendation around a national mental health workforce strategy is also very welcome, but I would suggest that the proposed parameters are too narrow in their focus on the clinical end of the workforce spectrum and that to truly achieve the whole of government reform of the mental health system, the workforce strategy must incorporate consistent professional development requirements and adequate funding to enable those for workforces that are not exclusively in health but in the social determinants portfolios as well.

The workforce with primary perview over infants, children and young people again, must include key competencies around engaging constructively with parents about their child's development.

We will be making a more substantial written submission further addressing the draft report. But for brevity sake, I thought I'd give more time to questions so that you can target further information that may be useful to you. In addition to the areas covered so far, I can speak to the examples of recent population roll outs of parenting support in Australia, including in Queensland, where the state government has made Triple P available freely to families for the last four years, reaching an estimated more than 335,000 parents and carers, as well as in Western Australia, where the government is offering parents free access to positive parenting seminars in their local school or child and family centre as part as the kindergarten enrolment process, and more recently, to reach parents and children making the transition to secondary school.

I have examples of implementation and outcomes of parenting support used across four of the major objectives areas identified in the draft report, including early childhood, school settings, workplaces and the justice system, and I'm also happy to discuss with you how parenting support that is delivered in partnership with existing social services and community infrastructures systems is most effective and, indeed, most cost-effective. Thank you.

PROF KING: Thank you. Now, you referred to a number of cost-effectiveness studies and evaluations, particularly of Triple P.

MS MARKIE-DADDS: Yes.

PROF KING: If at some stage, and it may be in the submission, just so that we have the links so that I make sure that the relevant people on the team can find those, that'd be fantastic.

MS MARKIE-DADDS: Sure.

PROF KING: A number of questions; but let me start off at the end. Parenting support; so one of the things that I do get concerned about with parenting support type programs such as Triple P - you mentioned the one in WA - is that there's a self-selection. So it's been put to us the problem is that it's the parents who actually aren't so much in need of the support are the ones who are much more likely to say, 'Yes, we'll do the program,' and the families and the parents that really need the support and the information are much less likely to do the programs because they're the families that are already under stress, whether it's financial stress, whether it's other issues in the family and so on.

So it's been put to us that, you know, you might get these great evaluations where they're done on selected groups of families, but when you actually roll the programs out, at least it's been put to us, they don't work because the wrong families engage.

MS MARKIE-DADDS: Okay, so I would challenge that we're not able to reach vulnerable families. So let me just give you some data from Queensland where we've been doing the roll out. So essentially here, I guess essential tenant of Triple P is that we're using a universal delivery system. So we're making it normalising, destigmatising to attract all families to come along and access parenting support.

So similar in WA and in Queensland, it's offered universally and it's great if you can pair it with, like, starting kindergarten. It's as normal as enrolling a child in kindergarten that parents also attend a positive parenting seminar or as you're child makes a transition to high school. That's another good check in time for parents to access parenting support.

Also, making programs available in a multitude of formats. So rather than one on one face-to-face traditional therapies, we've got programs available in large group seminars. So families that want to just come along and listen and don't want to put their hand up and speak, they can feel comfortable in that large group environment.

There's also multi-week smaller group programs if families prefer that. There's self-help options with workbooks and online programs. There's telephone assistance options so we can reach families that are rural and remote or work; child care issues, unable to access face-to-face services. So making the programs available in a whole range of different delivery formats means that there's something for everybody and they can choose the format that matches their particular requirements.

So just to give you some indication of the reaching Queensland, it's been going for just over four years now. We've estimated we've reached 336,000 parents and carers. Of those,

54,000 are opting to do the program online. So we have a version for parents of younger children under 12 and a version of Triple P for parents of teenagers.

So working through the program, it's supported via a communications campaign to raise awareness and to let parents know where to access some support. We've got a comprehensive website specifically for Queensland parents with information on as well, and where they can find sessions and enrol in events or find a provider.

In terms of the state-wide representation in Queensland, at the moment, our data is looking at how many health care card holders we're attracting and that's our proxy indicator of a low income family.

PROF KING: Yes.

MS MARKIE-DADDS: The estimate is about 20 per cent of Queenslanders would have a health care card. Our current number of parents completing Triple P is 29.6 per cent; so they have a health care card. Aboriginal and Torres Strait Islander families: This is an underestimate because it's only those who are accessing services through a web-based portal. So they're registering for a seminar, an online program.

PROF KING: Yes.

MS MARKIE-DADDS: We've estimated about 3.8 per cent of Aboriginal and Torres Strait Islander adults in Queensland. 4.3 per cent are identifying as Aboriginal Torres Strait Islander on our online registrations.

In addition, we've trained over 125 practitioners who work specifically with Indigenous families across Australia and particularly up in the north. Speak a language other than English: The community prevalence in Queensland is about 7 per cent. 14.5 per cent of our families report they speak a language other than English at home, and 16.1 per cent of families in Queensland are single parents and we've attracted about 24 per cent are reporting that they're single parents accessing services.

So in terms of those core indicators of vulnerability that governments often use, we're certainly reaching those cohorts and it's similar numbers in terms of enrolments in our online programs. So the reach. It's not so surprising I guess if you're low income, you're a single parent, you can't access child care, transport or you're looking for out of hours.

PROF KING: Yes.

MS MARKIE-DADDS: So we do find that a lot of our online users are using the program between 9 pm and midnight to work through the program. There's a number of randomised control trials on the impact of the online program showing that it is as effective as our equivalent face-to-face, 1 hour a week for 10 week program and it's shown to be effective with children - well, families presenting with children with quite significant behavioural and emotional problems, including ADHD symptoms, early onset conduct problems.

PROF KING: Costs?

MS MARKIE-DADDS: The cost of the online program?

PROF KING: Well, do both for me. So costs to the parents who attended the 10 week program and the cost of the online program.

MS MARKIE-DADDS: Well, in Queensland the Queensland government is providing the access to the online program. So in Queensland the cost repair ant is nil.

PROF KING: For the online program?

MS MARKIE-DADDS: Yes.

PROF KING: M'hmm.

MS MARKIE-DADDS: A parent interstate accessing the program, 7995 for the program.

PROF WHITEFORD: Online program? And what about the face-to-face or the group - the one tentative (indistinct).

MS MARKIE-DADDS: Well, it'll vary if they're - like, in Queensland NGOs and health departments are providing it free of charge to their service deliver. If you got to a private psychologist those are the rates. So the rates vary, probably \$100 plus an hour to access those programs.

So where a private psychologist delivers it, they would've been trained - to have some credentials to say, 'I can deliver the Triple P program that's got vedelity with - what's (indistinct) show in the clinical trials in (indistinct) process.

That's right. So our organisation, Triple P International, is essentially a professional development organisation so we have the licence from the University of Queensland to disseminate the program world-wide and so we run I guess dissemination implementation. So in Queensland, we've been with any NGOs and government agencies who are wiling to provide Triple P, free of charge to the end user.

So these are services that are typically funded federally or by the state government to provide parenting and family support from light touch or to intensive interventions.

PROF WHITEFORD: And apart from Western Australia and Queensland, other states that you're in?

MS MARKIE-DADDS: We're in most states but to varying degrees.

PROF WHITEFORD: Internationally?

MS MARKIE-DADDS: Twenty-eight countries that we're offering - that are running Triple P. We've got offices in about eight different countries and was translated in around 20 languages.

PROF KING: The program itself, how does it - well, does the program differ, is it modified at all depending on the background of the parents, perhaps their ethnicity or any other factors that may mean that their vulnerabilities, their ability to engage effectively with the parenting program changes? So how much flexibility is there?

MS MARKIE-DADDS: Yes. So there is quite a bit of flexibility within the program. We always talk about it as flexibility and fidelity. So the core principles of Triple P remain consistent, the core strategies within the program remain consistent, but the way in which they're presented and shared with families will vary depending on their particular circumstances. So if you're familiar with Triple P, there are a whole range of resource tools that can be used to supplement the information that's provided, videos, tip sheets, workbooks and so on.

But if we're working with an illiterate family, then those tools aren't useful for that particular family, they are of more benefit to the practitioner and making sure that the practitioners are sharing accurate information with the family. But the way they share that information will be tailored, depending on the presenting family. So whether you're sitting under a tree out in regional Queensland or you're in a more structured formal environment in an office clinic.

PROF WHITEFORD: So one of the recommendations in the draft report, and you've referred to it, is the idea of a three year old social and emotional wellbeing check. Now, one of the concerns that's been raised there, there's been a few, one's around stigma of trying to diagnose a mental health problem in a three year old, which I guess we're not trying to do. What we're trying to do I guess is identify children at risk or where some sort of help is needed for the family. So the second issue therefore is once you do the checks, what do you if you find a family that needs assistance and because by doing the checks you're likely to throw up considerable unmet need. What's the capacity of a group like Triple P to respond to that if that's, you know, one of the solutions?

MS MARKIE-DADDS: Yes. Well, we would think it's about embedding the support in the workforce that has the most contact with those children of that age group. So in particular, the early child education and care sector, so particularly now over 90 per cent of four year olds are accessing kinder or preschool in the various states and territories. So it's about embedding the support or the skills within that workforce to support those children and parents.

So it's that early intervention as well. If we're getting in early, it's light touch interventions, so things as simple as seminars at kindergartens and preschools and it's upskilling the existing staff within those services. So in WA, kindergarten's offered through their state schooling system, so it varies in from jurisdiction to jurisdiction as to who offers that part time year of schooling. But in those jurisdictions where it is in the school environment, they have the luxury of being able to use the school based staff, so they have school psychologists who are able to then run those seminar events.

New South Wales is in the process of increasing their workforce of psychologists and counsellors, particularly in the high school setting. And again, they're the sorts of professions where they could be running transition to high school seminars on positive parenting and

even picking up on some of the topics of the last speaker, a whole host of seminars could be run through the year, targeting the parents of those age groups.

So we would say I guess that key point I wanted to make was when we have just started doing the positive early childhood education program, which has been developed specifically for educators and it's really come out of that demand because educators were asking us, well what can we do in our environment? Because we're supporting parents on the one hand with Triple P and what can we be doing in the centre?

The thing that I found most powerful was that it wasn't until they did the program that they realised that they had their own capacity to actually make a difference in that child's life and they were always looking for where can we refer this child to rather than what can we be doing in the day to improve their resilience and self-regulation skills.

And that's really I guess what we'd be looking at identifying in that three year old health check, those children that are having difficulty regulating their emotions and coping with changes, who are easily distressed or upset. And then if we can provide some tips and ideas to the staff within those early childhood education and care settings, we can make a significant impact then so that they make a smooth transition to that first year of formal schooling.

So I think if we looked at that AECD data, the Australian Early Development Census Data, New South Wales, I think it was last year, they looked at all of the children starting their first year of formal school and they could identify those children who scored as vulnerable on measures of social competence and social emotional adjustment and those are the children that perform poorly through the literacy and numeracy tests and so on.

But if we can get those support and help those parents with those children at three, and it is usually around routines, like a good sleep routine, a good eating routine, a good getting out of the door in the morning routine, then those make a significant change to that child's life.

PROF KING: Other doorways to the service, so workplaces or other - - -

MS MARKIE-DADDS: Workplaces are ideal if we can I guess put the systems in place that allow the staff who wish to come to the events, the freedom and the ability to come. So when we first started the Triple P rollout in Queensland, we did have an employee assistance program strand, I guess, and we offered seminars in government facilities for about 200 odd workers came along. They all found seminars successful or effective and beneficial for them, but it was more about pragmatic issues about whether they were able to come along or at the last minute work was too - issues arose that made it impossible for them to attend and so on.

But having the seminars supported by the online program, so there was always that backup option that if families, if they couldn't come during work time, they could come after hours via the online program.

There's been a bit of research that we've done, particularly with teachers, with - I'll just find some notes, with workplaces who have been offered Triple P as a workplace program, where

we offered it to them through the education department in Queensland a few years back, I can send you the research paper for this particular one, offering it to teachers who were parents.

So we spoke to them as though they were parents, well they were parents, they went through the program as a parent would experience the program. But they were able to generalise the strategies and information that was presented for them as parents to their classrooms and reported lower levels of classroom stress and increased confidence in their ability to respond to children's behaviour and most significantly they reported that they were much more less likely to consider resigning in the next five years.

So when - and that's part of the rationale and why we're starting to move into providing an adaptation of the program specifically for those in education centres and starting with that early childhood.

PROF KING: That would be the further development - part of their further development?

MS MARKIE-DADDS: Yes, yes. So at the moment we can - - -

PROF KING: Professional development - - -

MS MARKIE-DADDS: Yes, we're supporting teachers more to provide advice specifically to parents though.

PROF KING: Yes.

MS MARKIE-DADDS: Yes.

PROF KING: All right. Thank you very much.

MS MARKIE-DADDS: Thank you. Was there any other particular research references or areas of research that you were interested in? I've got the cost effectiveness, broad research outcomes - - -

PROF KING: The evaluations. I'll let Bill grab you if there's other things that we need.

MS MARKIE-DADDS: Plenty of evaluations of real life rollouts, yes.

PROF KING: That'd be fantastic.

MS MARKIE-DADDS: Thank you.

PROF WHITEFORD: Thanks very much.

PROF KING: All right. We're going to have a break for lunch until 1.30. We've got a couple of people by phone after lunch. Anyone else? Bill?

UNIDENTIFIED SPEAKER: No, I'm just with Carol.

PROF KING: No, sorry, I'm looking past you to Bill. Bill's sitting over right behind you. Sorry. I noticed before when I mentioned Bill and you saw my head looking there. So just lunch now and there's two by phone afterwards. All right. Back at 1.30, guys.

LUNCHEON ADJOURNMENT

RESUMED

(Telephone link established.)

MR WELLMAN: Hello.

PROF KING: Hi, is that Robert?

MR WELLMAN: Speaking. Speaking.

PROF KING: Yes, Stephen King from Productivity Commission here.

MR WELLMAN: Hello, Dr King, yes it's Robert Wellman. We met at the meeting with the Mental Health Coordinating Council. You might remember.

PROF KING: Yes. Yes.

MR WELLMAN: And we had a brief conversation but you were in a hurry to get your flight.

PROF KING: Yes. That sounds pretty much like me, yes.

MR WELLMAN: Well look you're all to be congratulated, it's a huge task and I've been listening to my colleague from Mental Health Carers New South Wales, Andrew Pryor was on the public hearings and I've been hearing a lot of it.

PROF KING: Yes.

MR WELLMAN: As you know I'm a (indistinct) - - -

PROF KING: Hang on. Before we get started, because we are on transcript, so do you mind just formally stating your name, your position and then, yes, any intro remarks you'd like to make.

MR WELLMAN: Yes, sorry. Yes. It's Robert (Indistinct) Wellman. I'm an aged pensioner and I'll be 75 next birthday. I've been a mental health carer for 20 years and I've done voluntary work in the mental health sector and I'm currently on the board of Mental Health Carers New South Wales.

PROF KING: (Indistinct).

MR WELLMAN: I've got a - I'm a retired TAFE teacher and I've got a basic science degree. So I understand a bit of science but of course at times I'm out of my depth. So that's where I sit, yes.

PROF KING: All right, and - - -

MR WELLMAN: (Indistinct).

PROF KING: Yes, so what would you like to tell us?

MR WELLMAN: Well, I suppose my goal in life was to have my son in a better position before I drop off the perch. So I've listened to a lot of the hearings and a lot of feedback and there's huge contribution. What the - there's been a lot about early intervention and schools and everything like being involved. I just wanted to change it a bit away from the pharmacology where local mental health service tick the box and it becomes an Olanzapine or a Clozapine culture sort of thing, and move away from that to technology that's being done overseas in relation to treating mental health because I'm sure if we were to pour more funds into the research there'd be a cost saving, which is what you guys are looking at.

There was a study done at the Philadelphia University in the States. It was a huge sample, 700,000, and what it showed was that those people that showed symptoms, not necessarily a diagnosis of OCD, obsessive compulsive disorder, but those people went on to develop more serious mental illness. So if we can stop that trajectory that'd be wonderful. One of the things they do in Finland (indistinct words) is open dialogue, which no doubt you've heard about where they bring in the school counsellor, all the parents, the siblings and everything and work through the issues early in the piece and as a result of that their mental hospitals are empty and they get employability results nearly equivalent to the mainstream population.

Now the bit I want to talk about is other treatment things that are being done. One in particular is targeted TMS. This is where they put the photo of the brain up and they stimulate the frontal lobe and hopefully pick up the connections into the (indistinct words) where a lot of these (indistinct) communications take place. Those two researches are being done - and there's two lots, one up in Queensland with Dr Luca Cocchi and Professor Breakspear and the other - and they link with each other - is at the Epworth centre with Professor Paul Fitzgerald, and as we speak a family member is doing that TMS clinical trial down there with Professor Fitzgerald. So that's looking promising. (Indistinct words) - - -

PROF KING: Sorry, just to clarify, so TMS?

MR WELLMAN: Trans (indistinct) - no, sorry, trans magnetic stimulation.

PROF KING: Thank you.

MR WELLMAN: Targeted trans magnetic stimulation. The other one which has got FDA approval in the States is dTMS. So that's deep brain TMS and it's got FDA approval and I we

do have two machines here. One Professor Paul Fitzgerald's got, and one I think it's at Black Dog. Now they haven't been used because of some hitch about - it's so expensive they've got to put a card in or something and that clocks up (indistinct) dollars going to BrainsWay in the States. So it's a BrainsWay machine that fits over the head like a hairdryer, and they've had a 38 per cent efficacy in the States. Now that's another worthwhile thing which is - both those things are unintrusive compared to DBT and would be really worthwhile to pour funds into that research because even if there's only a 30 per cent efficacy it would reduce the numbers in acute care.

So I'm just looking at, you know, perhaps changing the waking a bit away from every conference I go to either have got another neuroelectric that doesn't have the same metabolic syndrome etc. etc. well we need to move away from that to these newer technologies and that's sort of - I haven't had - I hoped to get the research papers to you on all of this I'm talking about, I haven't had a chance yet. And the last one I want to mention is focused ultrasound, and no doubt you've probably have saw the paper about the guy with the tremor and they did the focused ultrasound and it stopped the tremors. Well, they're now using that, that's a bit more intrusive because they use the sound waves and they can link it up really accurate on the part of the brain and it's much less intrusive than DBT.

And there's a lot of research going on there in Canada, Toronto, in relation to focused ultrasound, and we're talking about depression and OCD here for these treatments. So that's basically what I'm on about to spend more funds and look at other ways instead of neuroelectrics antipsychotics, you know. Curtin University did a huge research paper on neuroelectrics, and basically I spoke to the lady, a professor there, and she gave me the paper. Basically what she came up with - she did an enormous, a hundred and something references of research she'd looked into and since the introduction of these first generation neuroelectrics the incidents of mental illness there's a trajectory upwards, an exponential increase in America, UK and Australia and these countries since their introduction.

Now in other countries like Africa and Asia countries there's - the incidents of mental illness stayed the same. So she's arguing that there's a case building not to use them at all or only in very rare cases and of course you've seen the present patients in the public sector, people coming in, the side effects, metabolic syndrome and the shocking toxic effects that these - especially Clozapine, Olanzapine cause to these poor people. So that's her argument. It's another bit of research that people probably haven't heard about. And (indistinct) - - -

PROF KING: Sorry, that was a researcher at Curtin University, did you say?

MR WELLMAN: Yes, it was. It was Professor Kate - it's a Russian name and it begins with - starts with K - Koskoski or something like that.

PROF KING: That's all right. We can try and find it, that's easy, yes.

MR WELLMAN: Yes. Yes, so that was - but it was a huge - it went for a number of years. She did a lot of research in relation to neuroelectrics and that was the conclusion they came up with. And the final thing I wanted to say, Dr King, is that the coroner is often - you know, his recommendations, some of the - if you read - they're open to the public, some of his reports in relation to inquests and he's highly critical of the management of these people and

what should be done. But government seem to not take any notice even though the 2009 coroner act is a very powerful piece of legislation and the coroner is in a very - some of his findings have been very insightful and as far as I'm aware there's very little data in relation to analysing the coroner's inquest reports to try and pick up some kind of pattern or some kind of trend.

And I don't think any university or government authority has done that. When I've raised it with Suicide Prevention they said "Rob, there's no political appetite." Well, you know, we're looking at a huge trajectory, you know, this is really vital to the country and as KPMG - the report there said, you know, we're losing a generational productivity and costing the nation a fortune. We're pouring buckets of money into it but there's still a trajectory. So I would have thought, just from my basic science and enquiry for an old retired pensioner that there should be more research in relation to the inquests and those hearings and the decisions that they hand down, because it may well be there's a trend.

I've noticed where there's a lack of communication in relation to medication when they're released from acute care, and things like that. I've only sort of touched the surface of it, but yes that's all I wanted to say coming from a research and science perspective.

PROF KING: Yes.

MR WELLMAN: To really have a look at that because that's where in the long term I feel the solution lies, not to be stuck in the medical model and, you know, the same old story, you know, the guy writes out the script, "How you're feeling?", gives you another script and nothing much happens and no novel techniques are seldom tried.

PROF KING: Yes.

MR WELLMAN: He did five weeks trial up in Queensland. He did one the middle of this year at Epworth, Monash University, and at the moment he's doing a third one after the washout period in the other one, and in fact I spoke to him on the phone yesterday and he was quite lucid and I'm hoping this time he's not the placebo and got the active treatment, because half of them are placebos so you - - -

PROF KING: Yes.

MR WELLMAN: - - - spend all this time and effort and you might not get a hit. But anyway the research is really - in these new technology - worth pursuing. I really mean that, Dr King, I'm very - and if there's anything I can do to assist or follow up with research papers, I've got quite a number of them, I'd be prepared to do that.

PROF KING: Okay. Thank you for that. When you say they're - I mean they're new technologies but they're still medical technology. So when you say - you sort of - you mean - when you say non-medical do you really mean non-medicine based as in non-pharmacological?

MR WELLMAN: (Indistinct words) pharmacological.

PROF KING: Yes. Okay. Okay, yes.

MR WELLMAN: So they're probably - yes, I'm probably wrong there. They're probably still medical, yes, non-pharmacological, you know, of the - I know from my volunteer work some of the poor sods are on a plethora of medication.

PROF KING: Yes.

MR WELLMAN: And yes it's - I can't - after that research done at Curtin University I really can't think that's the answer in the long term at all.

PROF KING: Yes, and just to clarify the research at Curtin that was just looking at the neuroelectrics class of medicines.

MR WELLMAN: Yes, so research in relation to neuroelectrics. That's right.

PROF KING: Okay. Yes. Yes.

MR WELLMAN: The antipsychotics, yes.

PROF KING: Okay.

MR WELLMAN: All the side effects and trends and she did a massive literature survey and summarised it all. I think it was done in conjunction with Mental Health Carers Australia or one of those people, I'm pretty sure.

PROF KING: Yes.

MR WELLMAN: And she got funding for that, but it was very good and she had every day cases of people suffering on the neuroelectrics and what happened, and it's backed up by the research and then of course you've got the other three things, the targeted TMS - this is different to just straight TMS, so it's targeted - dTMS and focused ultrasound are the other three I mentioned that - - -

PROF KING: Yes.

MR WELLMAN: You know, they're very much - see in the States they've got a hundred sites for the dTMS, the BrainsWay machine. A hundred sites. We haven't even got one up here. Not one.

PROF KING: Yes.

MR WELLMAN: So, you know, we seem to be - like in some areas of medicine we're leaders - - -

PROF KING: Yes.

MR WELLMAN: - - - but in mental health we seem to be really dragging the chain compared to what's happening in other parts of the world, the western world (indistinct).

PROF KING: Okay. I mean with these particular interventions though, whether it's focused ultrasound I understand is really - has been shown successful on certain neurological conditions so sort of tremors, Parkinson, those sort of conditions, I - - -

MR WELLMAN: Yes. They're doing a trial for OCD in Toronto at the moment, yes.

PROF KING: Okay. Yes. TMS - and again apologies I don't know the details on targeted versus deep brain and so on, but mainly for depression I thought that had been shown - - -

MR WELLMAN: Yes, it's mainly for depression but they've also got FDA approval for dTMS for OCD.

PROF KING: Okay.

MR WELLMAN: OCD, there's three subsets of OCD. You've got the symmetry, you know, they want the pencils all lined up. You've got the contamination, the hand washer. Then you've got the intrusive thoughts which is the subset - - -

PROF KING: Okay.

MR WELLMAN: - - - the most difficult one to treat. In other words they have got refractory OCD. It doesn't respond to cognitive behaviour therapy or exposure response therapy.

PROF KING: Yes.

MR WELLMAN: So that's where - and it's interesting that that subset, the intrusive thought subset of OCD, according to the Philadelphia study is the one most likely - if you pick it up early when they're kids, are the most likely subgroup or subset to develop more serious mental illnesses.

PROF KING: Okay.

MR WELLMAN: And that's why I'm very interested in OCD because OCD if they've got that as a child they're more likely to develop a mental illness in their teens and sort of that 15 to 25 age bracket.

PROF KING: Okay.

MR WELLMAN: And so - yes, so there is a lot of work being done with targeted TMS and dTMS now for OCD and equally of course as you correctly say for depression.

PROF KING: Okay. All right. Okay. Well, thank you, Robert, that's been really very useful. If you've got any links to stuff - I suspect the teams got access to the published

studies but if there's anything that you've got that you think isn't generally available or maybe a bit obscure and we may not have - - -

MR WELLMAN: Yes.

PROF KING: - - - please just send through the links to Bill and that'd be fantastic.

MR WELLMAN: So if I send them to Bill - - -

PROF KING: Yes.

MR WELLMAN: - - - hopefully that'll be a contribution.

PROF KING: Yes, that'd be brilliant. So thank you for that.

MR WELLMAN: Yes. I appreciate your time and it's got to be the hardest topic ever. You're doing - really giving everyone a fair go because there's so many groups out there that are doing good work and that, but how you coordinate it all together it's just such a huge task, and also politically, Dr King, the politicians that we've had - any maybe don't quote me on this one - the politicians we've had over the years, none of them have a science background and the science lacking in the departments, so there doesn't seem to be the lobby for more work done in research in new technologies for treating mental illness.

PROF KING: Yes, I don't think there's too many scientists in parliament in general but - I think they're all lawyers, aren't they?

MR WELLMAN: Something like that or professional politicians.

PROF KING: Yes.

MR WELLMAN: But in saying that, to have someone - like Geoff Gallop suffered from a mental illness (indistinct words) - - -

PROF KING: Yes, there's people with lived experience there, you're quite correct.

MR WELLMAN: Because these people, when I visited the labs and saw what was going on, I've got a basic science degree, the algorithms and the work they're doing is just truly amazing. And they're really smart guys. They're the ones that need to have the support to try and come up with these new techniques and that to try and relieve the suffering of these poor people. You know, it's - I don't know whether you've visited mental hospitals or acute care.

PROF KING: Yes.

MR WELLMAN: But no, it's - - -

PROF KING: Been on the wards, so yes.

MR WELLMAN: Yes, it's terrible.

PROF KING: All right, Robert.

MR WELLMAN: All right, thanks.

PROF KING: Thank you very much.

MR WELLMAN: Thanks so much for being congratulated on your work.

PROF KING: Thank you.

MR WELLMAN: So good luck so far. Okay.

PROF KING: Thanks, bye.

MR WELLMAN: Bye-bye.

(Off record discussion.)

PROF KING: What would you like to tell us?

ANONYMOUS: Thank you. Okay, well I'm a person that has tonnes of experience in what I'm about to tell you, but I'm also speaking mainly as an advocate. I am a retired health professional, but I did work in this area. And I've (indistinct) been given the opportunity to talk with you today. I've read much of the draft report and many of the submissions, however, I did not find reference to the issue that I'll raise for consideration today.

I became aware of this issue first about 18 months ago, and growingly over the last 18 months as I tried to assist a young man in this situation, trying to find knowledgeable family law and mental health assistance, as well as organise other support.

During this time, I also experienced a horrific grief and emotional pain suffered by those involved and found myself feeling quite helpless, unusual for me, and quite anxious as I tried to assist and find a timely solution to this problem, which I realised would otherwise only get worse over time. So the problem that I'm referring to is the phenomenon that often occurs in high concept, acrimonious divorce or separation, where one parent intentionally, often very covertly, emotionally and psychologically manipulates a child to turn against and reject the other parent for no logical reason, and when there was a previous loving relationship, often because the child has internalised (indistinct) of that parent. Children need to love and be loved by those parents and extended family, unless there is a valid reason why it's not in the child's best interests.

So this phenomenon has been described since the 1980s, and likely before, and called various parental alienation, programmed and brainwashed children, pathological alignment, attachment-based parental alignment – alienation, I mean. Attachment related (indistinct) divorce, contact refusal, contact failure. And I quite like the term "contact failure", because

it's a bit less – less (indistinct) than the others. So like, parental alienation seems to be the common (indistinct) term at the moment.

There's been some controversy that surrounded the term, and some people are avoiding the term "parental alienation". So although there's disagreement about names and its exact description, but there's certainly agreement that the phenomenon (indistinct) damages of child and parent as well as extended family who are often also alienated.

One model described the phenomenon in terms of attachment theory, conflict, trauma, family systems, personality disorder and neurodevelopment of a child in a parent-child relationship, and calls for consideration of a special population group of family requiring assessment and treatment by professionals with specialist knowledge, training and experience and supervision. Because of (indistinct) studying from social psychology (indistinct).

Much to do with it is counterintuitive, as has been pointed out by a number of people. It's also been described as a form of family violence, because (indistinct) for other, using the child as a weapon, and then also described by the (indistinct) as a form of psychological child abuse and can be considered elder abuse because of the alienation of the grandparents.

The American Psychological Association states that psychological abuse is just as damaging as sexual or physical abuse, because it's harder to show. The research – quite a bit of research has been done by this and it does show that the alienated parent, or the person stopping the contact has significant psychopathology, often personality disorders, especially with cluster B, delusional disorders or Munchausen. There's lots of detachment between the parents and child – the parents without the contact, (indistinct) pathological enmeshment, children are traumatised by this and it's (indistinct words). Children want the alienation to stop, and – (indistinct words) one needs to look at the context in which that occurs, and the influence that it's been on the child.

So stopping this is imperative for promotion of the best interests of the child. This is not gender specific, but more commonly carried out by the (indistinct) parents, whether that's male or female. Alienation has been likened to cults and brainwashing. It's a global problem, and there are efforts in many countries to address the issue, and there is an international study group.

There has been a prevalent – recent prevalent study showing that in – I think in Rosen, Canada, Canadian town where they did – they came out with – I think 22 million parents of the 6.7 per cent children moderately, severely alienated, of the parents that felt that they'd been alienated, and so that came out at one point through the (indistinct) population, of the number of children. So there's severe long-term and short-term consequences for the child and for the other parent as well, such as poor self-esteem, depression, adult attachment styles, alcohol misuse, poorer self-direction and cooperation in the child. There's also depression, trauma symptoms and suicide within the alienated parent.

Often it's thought that they've often been poisoned by prior and continuing domestic violence of the emotional (indistinct) type, and coercive control to sabotage the child's relationship with the other parent. So currently, we're just trying to - I'm sorry, it's a bit - - -

PROF KING: No, no. This is fine. Yes.

ANONYMOUS: So there's some gaps in service availability and no clear - there are gaps in service availability and no clear pathways. So it's a family, mental health and child protection issue. However, it's not addressed as such, as it's usually dealt with in the courts as a child custody issue, where most, if not all, have inadequate training skill, knowledge, or experience to identify and assess, diagnose and develop treatment for - and referral to treatment. There's also a lack in (indistinct) practitioners of this phenomenon, and also, there are very few services in Australia, especially at the severe end of the spectrum.

So once it's in the court, it's too late, as the damage is already done. The more entrenched the influence, the harder to reverse. The longer no contact, more difficult to reunify. At the time from first signs to complete contact failure can be as little as three to four months. So we've got the ambulance at the bottom of the cliff; we need to act well before this, well before the fall off the top of the cliff.

From my experience of trying to help the person, and I may not know - obviously, we don't know everything that's going on, but I have been studying it quite intensively (indistinct). But there don't seem to be systems in place, and certainly not systems between - certainly not coordination between systems, and no clear pathways within or between family law, child welfare, and natural health and other systems.

Even couple counsellors back further, seem to not be well trained in our family systems, and don't often identify what's actually going on when this is actually going on. We've got the child support issue where the use of custody and visitation is used to fix the level of child support and can distort decision making about the welfare of the child and be a perverse incentive for one parent to deny the other extensive time to maximise their income.

And although grandparents, uncles, aunts, cousins, can provide a refuge from the chaotic home for the child, sometimes some of them align with one of the parents at break-up, and may even enable or even increase the alienation of the children who have (indistinct). So it's a population health, as I see it. So these children that are losing the contact to one parent experience - often have experienced in their home multiple adverse childhood experiences which are linked with their (indistinct) and often they've got, you know, mental illness in the family, family conflict, divorce, and child abuse, just to start with. There's four of the eight.

So they highly pre-exposed to lifetime mental health and physical health issues. So there's costs to the individual, community, and economy, and loss of the family resources; the financial in having to go to court, to try and just have some normal upbringing, and for both parents to fulfil their responsibility to assist the child in their development. It wastes a lot of emotional energy. There's time off work by the parent trying to navigate through the system, and then probably presenteeism because they're probably preoccupied with the problem, and setting up and running two homes, of course.

Representing themselves often in court, because it's so expensive, and a lot of family lawyers aren't aware and don't have training in this area. The parent without contact often requires intensive, expensive, psychotherapy themselves because the complex PTSD they're suffering from the relationship, and the ongoing emotional abuse, often from using the child as the

weapon. So, the (indistinct) to health services, but also the police criminal justice system in the short-term and also the long-term.

And then there's the cost of transmission of this trauma into the next generation, with the repeated pattern, because often that's what then happens to the children that are being - not had the contact, grow up to often be alienated from their own children, and with ongoing issues. So, if (indistinct) the development of full-blown contact failure. Failings in budgets and court systems in handling these cases from induction to (indistinct), on social services, medical facilities, in the treating the child in the long-term, and of course other family members.

Also, from what I can see, and I've talked with a lot of groups, there seems to be a lot of suicide of males and females that have lost the contact in this way from their children, and - but it's not reflective in any statistic, because I think the reason for suicide isn't collected, but I'm not sure. So there's also that cost, and that's a really important link. Because there also is - has been reported self-harming and suicide sometimes of the children in their teens when they've been alienated or lost contact with one of - a previously loving parent that, you know, hasn't committed any crimes or abused them in any way.

So, I was looking at the cost of that and the cost of - then the kids get into trouble in their teens, on drugs and alcohol. You've got police, criminal, and juvenile justice and correction costs, and then loss of productivity in the next generation. So what's happening? Well, lots is happening on an international level, like - it's been going for about 30 odd years now, and it seems that it's been very slow. That's why I wanted to bring it up with your Inquiry.

So there is an international study group. There are useful codes to be used in the DSM-5 and the ICD, but they don't actually mention criminal alienation. However, the new ICD-11 is going to include criminal alienation as a term in the index, which is a little bit of a step forward. The University of Tasmania, there is some research going on in this area, and some people associated there just, in the last two months, published a book on understanding and managing criminal alienation. (Indistinct), which is good.

There are lots and lots of peer support and online websites of varying system content, but a lot of peer support, which is terrific. At the severe end, often it's recommended intervention is - that you might need to separate the person who's doing the alienation for a period of time from the child, so that - to try and heal the family, and there are some people that run some groups for that, but there's very little available in Australia.

There's an Eeny Meeny Miney Mo website that provides a bit of information, and For Kids Sake is doing a lot of work in this area. Brazil and Mexico have made some legal changes, and in Ireland there's just recently been some - a couple of counties - a couple of county councils have recognised criminal alienation as both a child welfare and a child protection issue. In Israel, there's a retired judge that's writing quite a lot on this subject, with some interesting suggestions.

So there are many gaps currently as a - I think I've said that. Parents need to go to court to fulfil the responsibilities to co-parent their children. This is a psychological emergency for the children and the targeted parent, or the parent whose contact is being stopped, and it's

important that there's early coordination between the family law, mental health, and child welfare system. Early.

There are particular issues for men who are victims of domestic - this domestic violence, because there are, as it says, a big imbalance between the services available for a man and the services available for a woman when they're in this situation, even though men are one in - one-third of the victims. So we need a population health approach. It's a population health issue as well as a child protection issue, and so we need prevention at various levels.

So we need to educate the public and potential alienators or, as they're sometimes called, null-adaptive gatekeepers. Perhaps a social impact campaign. Educating professionals who are in frequent contact with children, such as educators, medical staff, and nurses in day care who might see early signs. Need early identification and immediate therapeutic intervention for the child and the parents, when identified, and where necessary, immediate court intervention, including orders for contact and treatment for the child.

Whereas in Australia, most people are not able to go to court and list (indistinct) through mediation, which is a fantastic thing for families and couples where both want to work something out. But when one, or both, don't want to do that, then it's really a waste of time and used as a delaying tactic to enable, particularly by the resident parent, to further entrench their ideas into the child. There should be strict sanctions where a parent refuses to comply with court orders for contact and/or treatment, including fines or imprisonment. Someone has recommended that. I don't know about that.

All these things I'm raising have been suggested by various researchers in the field, and I'm raising them as things to be considered by the system. So, in Israel, interestingly, they are going to ask, you know, if the contact stops, what are the problems with contact, and they're moving to - because also we have a problem over here with allegations of domestic violence or child sexual assault that often have to be disproved before the parenting orders can be considered.

But they're looking at possibly, instead of having that parent prove, or the parent who has no contact having them prove that the residential parent is alienating the child, or facilitating the child under the subject of the objection, that the onus should be on the residential parent to prove that there are justifiable reasons for the cessation of the contact. Sorry, I messed up a couple of things there.

PROF KING: No, no.

ANONYMOUS: They're two separate issues.

PROF KING: Yes.

ANONYMOUS: They have identified three levels of severity; mild, moderate, and severe, with different interventions. So, for instance, the mild; admonish and educate the parents. For moderate, coaching and family therapy, and for severe, we move the children from the abusive home, or the abusive parent. But also people have pointed out that use of the mild sometimes lulls therapists and legal people into a false sense of security in that, just because

it's called mild doesn't mean it is mild, and that needs to be addressed immediately anyway, otherwise it could progress on to the others, and quite quickly.

So I'll just say a bit more about the population health approach. Primary prevention, focusing on the entire population and may be at risk of parent/child contact problems after separation. For the public, this is mostly - I'd never heard of it before 18 months ago, and lots of people I talk to have never heard of it, unless they say to me, well, that happened to me. That happened to me, that happened to a friend of mine, or that happened to me 50 years ago, or that happened to me 10 years ago, or it's happening to my sister now.

So unless you're actually involved, you usually don't hear about it. So we need this - the public need to be made aware of the problem well before people enter into relationships, or at least at the outset of their parenting, and we need - possible need campaigns within the press, the TV, social media, high school, youth movement, pre-marital training, religious organisations, and community organisations.

And then the secondary prevention, which is the early identification and intervention for at-risk problems with problematic parental behaviour, or if the child's displaying reaction to the parental (indistinct). They need to identify the children at risk, parents at risk, and the parental behaviours that indicate family strife, and then refer to properly trained professionals for advice and intervention.

And then tertiary intervention for that more severe end is - needs to be immediate, interdisciplinary and professional, and involve lawyers, judges, therapists, and social services. So the lawyers need to be made aware of the phenomenon, causes and effects, and just need to perhaps consider whether they need special training and licencing in order to deal with cases involving children, and that they might need to be - file applications for immediate orders for reinstatement of contact where it's already stopped, and so injunctions to prevent (indistinct) of the parents.

PROF KING: So would that be lawyers working in the family court system?

ANONYMOUS: Yes.

PROF KING: Yes.

ANONYMOUS: Well, I'm meaning family lawyers, because I think - although, I suppose lawyers working in the juvenile justice system might.

PROF KING: They might also, yes.

ANONYMOUS: I'm not sure what other matters would be considered in other - by other lawyers, apart from family lawyers.

PROF KING: Okay.

ANONYMOUS: And family judges, family court judges, and including the court - the other court, the Federal court that hears family law matters, need special training in order to deal

with contact and other cases. The termination of (indistinct) came only after immediate interim orders to prevent deterioration into full contact failure, and for reinstatement of contact where it has already failed.

And orders for contact need to be clear, specific, and unequivocal. Where necessary, orders should specify sanctions for non-compliance, including (indistinct) for contempt of court, and zero tolerance for non-compliance. Because what happens often - also, I've become aware that, as far as I understand, the Family Court do not - and I don't think the other courts do - do not actually monitor the outcomes from their judgments, and so they don't really know, as in - whereas in health, you know, we monitor some outcomes to see if we've been effective. So there hasn't, as I understand it, been monitoring of outcomes, and might be a good thing to do.

PROF KING: Yes. I think that the Family Court, that one of the parents would have to reapply to the court if they felt that the orders weren't being followed by the other parent.

ANONYMOUS: Exactly. That's right, and that all takes time and money, and another point that has been made is that while there's - there is enforcement for child support payments, there's no enforcement of court orders. That the parent does have to go back to court and wait a long time, during which time there's more damage to the child. And doing more damage to the child.

PROF KING: Thank you.

ANONYMOUS: Sorry, I just had a few other - - -

PROF KING: Yes. Please, yes.

ANONYMOUS: - - - (indistinct) social services, child protection. But now had the gatekeeping of true alienation by a parent and the maltreatment of the child. So the child protection officers; should they get involved, and if so, when? And the social workers, and also the mental health counselling therapeutic services need to be able to get proper assessment and advice or treatment for children, or referral to good treatment for children of parents immediately, not - because time is of the essence.

PROF KING: Yes.

ANONYMOUS: Sorry.

PROF KING: No. So, thank you for that. You're completely correct. It's an area we haven't looked at in the draft, but it is an important area, and it will be one that our team will follow up. Now, the degree to which we go into it for final, there are - unfortunately, there are a whole range of areas where we're not going to be able to get into enough detail in final. But interestingly, from my perspective, you said the different people who haven't heard of it before.

As you started, I thought, yes, that's something that I should have thought of, because my wife's cousin went through exactly what you're talking about and we were here main

supports, because she was an immigrant to Australia, and quite bad situation of - well, alienation or separation of the children, actually quite strong manipulation of the children in that situation. So I understand what you're talking about, and also the effect that it can have on the relevant - on the children as well as the relevant parent.

But as I said, I'm not sure the degree to which we'll be able to get into it in our final report, simply because we've had to draw boundaries. But it will be something that the staff will take a bit more of a look at.

ANONYMOUS: Okay.

PROF KING: Harvey, did you have anything? No. Okay. Well, thank you very much for that.

ANONYMOUS: Okay. Thank you. Could I just say one more thing?

PROF KING: Please. Yes. No, no. Fine.

ANONYMOUS: It's just a thought at the end, but maybe the national policies that are developed for mental health and suicide prevention at least, maybe they include something to do with this phenomenon as well, being as (indistinct).

PROF KING: Yes. Well, and I'm also thinking about the role of the Family Courts. As you mentioned, the training of the lawyers, the training of judges. And again, this is one where I'm talking from personal experience, so of course you have, as you said, the orders to go to mediation, and there are - on numerous occasions, because the Family Court judges prefer a mediated outcome, but - which doesn't work when one of the parties, one of the parent's is not interested.

But to get the relevant lawyers involved at that stage, but of course, if they don't have the training to recognise what's happening, and that there may actually be a child protection issue, then it can fall through the cracks.

ANONYMOUS: Yes. And sometimes they don't believe the man. This happens also.

PROF KING: Yes.

ANONYMOUS: (Indistinct).

PROF KING: And either parent can be the one who's engaging in the manipulation of the children.

ANONYMOUS: That's true. Yes. The other thing was that often, when it becomes severe, often the person who files does have - it seems that they do have a personality disorder in that (indistinct) or also (indistinct) and so I thought there has to be - there is a link there with what's happening, you know, people like Spectrum and Project Air that I did approach them.

PROF KING: Yes.

ANONYMOUS: But I don't know whether they're able to be involved. But the thing is that often people with some of these disorders don't want to have an (indistinct) because they don't think they need it.

PROF KING: Yes. Okay.

ANONYMOUS: Anyway.

PROF KING: No, thank you very much for that. Thank you for taking the time and talking to us.

ANONYMOUS: Yes. And I can put in a written submission for you.

PROF KING: Of course. Yes.

ANONYMOUS: I'll tidy it up a bit.

PROF KING: Please do so. Yes. Okay.

ANONYMOUS: Okay. Thank you.

PROF KING: Thank you. Bye.

ANONYMOUS: Thank you. Bye.

PROF KING: Okay. Sorry. I need to finish, don't I? Yes. I need to officially finish. We are officially finished for today. We'll reconvene tomorrow in Brisbane. So the transcript can go back off.

**MATTER ADJOURNED UNTIL
TUESDAY 3 DECEMBER 2019**



Australian Government

Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

PROF STEPHEN KING, COMMISSIONER

MS JULIE ABRAMSON, COMMISSIONER

PROF HARVEY WHITEFORD, ASSOCIATE COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

**CENTRAL PLAZA ANNEX BUILDING 345 QUEEN STREET, BRISBANE
ON TUESDAY 3 DECEMBER 2019**

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PROF KING: Good morning, all. Welcome to the public hearings following the release of our draft report for the Productivity Commission's Inquiry into improving mental health in Australia. My name is Stephen King. And I'm a Commissioner of this inquiry and beside me are my fellow commissioner's Julia Abramson and Harvey Whitford.

Before we begin today's proceedings, I would like to acknowledge the and Turrbal and Yugara people 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 people in attendance today.

The purpose of this round of hearings is to facilitate public scrutiny of the Commission's work and to receive comments and feedback on the draft report. This hearing in Brisbane is one of many around Australia in all states and territories in both capital cities and regional areas. We will then be working towards completing a final report to the Government in May, having considered all the evidence presented at the hearings and in the 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 automatically be advised of the final reports released by Government which may be up to 25 parliamentary sitting days after completion.

We will conduct the hearing in a reasonably informal manner, but I would like to remind participants that there are 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 will be taken today – sorry, the transcript taken today will be made available to participants and 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 the issues raised in other submissions. I also ask participants to ensure their remarks are not defamatory to 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 and use the space by the tea and coffee area. If at any time you feel distressed, please approach one of our staff who will assist you and the staff members are at the back, Ros and Bill.

In the unlikely event of an emergency requiring evacuation of the building, the exits are located just directly across from this exit door here and upon hearing the evacuation tone please leave the building and assemble. The fire wardens will let you know where to assemble, but the formal assembly area is just in front of the building in Queen Street, unless given an alternative by the fire wardens. If you require assistance, please speak to one of our inquiry team members here today.

Now, our first participants today are going to be representatives or representative of GROW Australia. David, would you be able to just identify yourself for the record. The organisation you represent, despite the fact I just named it. And any opening remarks for the transcript.

MR BUTT: Okay. Thank you. My name's David Butt and I'm the National CEO for GROW Australia and thank you for the opportunity to be here today. And first off, my congratulations

on the draft report. I think it's certainly heading in the right directions, fantastic content in it; obviously, there's areas to be filled out and I'll talk a bit about that today.

And I want to make six points that I'll try and be as brief about as possible, but – and we'll elaborate on that in our submission to the PC by 23 January. But I just think it's – first off, I'd like to tell you a bit about GROW because I consider that will illustrate what I see as an important gap in the draft report and one that I think is vital to cover.

So, GROW was established in 1957 by people with a living experience of mental ill-health who saw a gap and a need and decided to fill it. And decades before words like – buzz words like 'co-design and co-production' were being bandied around, the GROW program was designed by consumers and delivered by consumers and that still remains the case today.

And GROW works on a model of peer support or peer to peer support if you like, and I think the draft report misses the difference between peer support and peer workers. It confuses the two somewhat. Peer workers, obviously are valuable addition to the workforce and yes, we need more work in that area and we need to find – to define what they do and sure, they probably remunerated and the likes.

But peer support occurs in everyday life and it's pretty extraordinarily valuable and if I use an example, I mean, just imagine if you didn't have each other working together to do this review and you were isolated in actually what you were doing and then imagine the benefits for people who have a severe mental illness. You come together, they look after each other, they care for each other. They build community together and I think the building community is a pretty fundamental part of it.

And with those who have recovered demonstrating to others that it's possible to live a fulfilling and contributing life, and they do that for short periods of time or potentially for even decades.

So GROW has helped tens of thousands of people to recover from severe mental ill-health, using an evidence based approach to peer support that involves GROW's distinctive services of fostering personal leadership and that's a really fundamental issue. A lot of these people have never had leadership responsibilities and part of the growth in their recovery journey is to take on increasing responsibility for leading things. Mutual help, peer support, self-activation which leads to self-actualisation, and ultimately recovery.

Each week about one and a half thousand people with mental illness and many with quite severe illness meet in small groups across Australia or via online eGROW services and go through a structured program which aims to give them a community in which they belong.

A structure where their lives otherwise have none and that's been a very important thing in our evaluations that people who haven't got structure actually enjoy having a structure that they can go to and work their way through it.

A way forward to grow and recover keeps them out of hospital, at home participating in the community and as far as possible being productive in the workplace. To attend, you don't need a diagnosis, even though most people do have a diagnosis but we don't ask them about that.

They're obviously potentially getting treatment elsewhere, although we do support them to actually maintain that treatment and take their medications and so forth.

You don't need a medical referral, although we're engaged in pathways, integrated pathways of care, for example, we send our field workers and our growers, the consumers into hospital – acute hospital units where they actually share with the people in those units, the potential to join a GROW group when they come out or participate in our other programs because we have quite a range of programs.

And so really giving them a way forward, opportunities when they leave hospital and a lot of people take that opportunity up. I think very importantly, GROW, the organisation doesn't facilitate the GROW groups. That's done by the consumers. So they take responsibility for organising meetings, evaluating meetings, reporting back at various leadership levels, something which they may never have done before and I mean, we have a – some – two residential services in Sydney and Canberra which look after people with dual diagnosis so they have a mental ill-health problem and a substance abuse problem.

And it's a group of people that a lot of others don't really want to, you know, they shy away from dealing with, quite frankly, and I think it's a huge gap in the system. We do that. And I was at our residential facility in Sydney recently, where a guy there had lost his home, his family, basically everything and he was at the end of – basically suicidal.

And he had taken on the responsibility for leadership of doing the cooking for the group and he was just ecstatic because he'd never had that sort of opportunity before in his life. And suddenly he was actually helping others and fulfilling a role that he never thought he would have done, so I think – that was just a beautiful example.

You mentioned in your Grace Groom oration which I think was terrific, that you didn't think the PC would be able to cover the role of volunteers. And my question to you is whether I'm describing – what I'm describing in terms of peer to peer support is an example of volunteerism. I don't like the term as a suitable description of what our programs do. I consider it better described as intentional peer to peer support.

But certainly these people helping and supporting each others are not peer workers. Many people stay for many years after they've achieved their own recovery because they value what others have done to support them and in turn once you give back to those who come after them and for me this is humanity at its best.

Is the service valued by the consumer? Most certainly. Our surveying over many years shows that the program helps people to recover, keeps them out of hospital, taking their medications, enables them to form relationships and build community, reduces suicidality and that's a big factor, and helps them gain and retain employment.

The full grit program including training costs about \$1000 a month depending on the number of participants which is very cost-effective when compared, for example, to the costs of hospitalisation or ED attendance. So we consider it vital that peer support be recognised in the final report in that it's properly funded and is identified as separate to the peer workforce.

My second point does relate to the first and that is that people across the spectrum of mental ill-health, from mild to moderate and severe and persistent, need low intensity services. Low intensity does not equal low levels of stress and depression or anxiety, nor does it mean minimal impact on outcomes. A step to care approach should relate to functional impairment and not to diagnosis.

Again, the value of the gain reflects the outcome for the consumer and investment in peer groups is a low intensity, low cost and high value investment, but it does deal with people at all ends of the spectrum of mental ill-health.

I'd also mention here that not everyone needs or wants an individual care plan or a case manager and I think you recognise that in your report. But it does actually, because of the stigma and discrimination associated with it put people off attending services. So I think we need to recognise the need for flexibility and choice, self-determination and enable people to manage their own plans to recovery.

My third point relates to the welcome, if incomplete, focus on the early years and impact of issues such as childhood trauma on health and well-being throughout the lifespan. The focus on the early years is vital, but it needs to begin well before school and obviously we're talking about vulnerable families, we're talking about during pregnancy, even before that. And I'd welcome the focus on screening and was somewhat surprised by some of the response in the media about that because I think it's a fundamental thing. So well done on that.

And keep going that way. But prevention should occur for all age groups throughout life. Early intervention should be just that. It's about a significant investment in the very formative early years of life which can have such an impact as we know.

We welcome the focus on schools, but consider the role being proposed for teachers as assigned well-being leaders, may be quite challenging to achieve a big change. I know you're teachers being trained to do this. But in many ways, if you have a sort of figurehead person who was supposed to be responsible for it, you still don't necessarily have the ability to do what needs to be done within schools to help students. I mean, certainly teachers are well-placed to identify students at risk and but they need others who are going to help them to deliver services and they need to be funded to do that.

And for all its value, BU does not do that. BU provides information, support, helps you develop a plan, but it doesn't actually deliver the service. And I just am concerned that teachers will be left somewhat – these teachers will be somewhat, 'I don't get that support.'

We took our program and developed it for schools into Get Growing, which has been extraordinarily well-received by teachers and students and counsellors and the like. It goes beyond information and training to where we actually deliver a 10 week program in schools and it deals with students who have been identified by teachers and counsellors as being at high risk and they go through a 10 week program which is a Step 1 which teaches them about how they've got personal value no matter what's happened in their past or what situation they're in.

And I've been to these groups and a lot of them come from broken homes or they've moved around a lot or there's family violence, abuse, et cetera, going on. But it helps them to know

how to value themselves to recognise they're not alone, how to support each other, how to keep safe, building community within schools so they support each other, how to set goals, be resilient; all those sort of things. And I think it's those sort of programs, whether it's ours or others that need to be included in what your well-being leaders might do in schools, because they need that support. They can't do it themselves.

And again, it's a – we've found that students who are often absent from school are more likely to attend school to attend our program than necessarily school itself because they value the – you know, the mateship, the camaraderie that goes on there. And we've had a lot of our adult members of GROW consistently telling us that if they'd had access to a program like that when they were young, their lives would be completely different and they wouldn't have suffered as much ill-health throughout their lives. And that we deliver for about 4000 a school over the 10 weeks and the evaluations demonstrate the value according to students.

The education system is a bit of a problem there because of course the way they operate we have to go from school from – to school saying 'Hey do you value this, would you like this to happen?' There's no systemic way of actually getting these sort of things through schools and I think that is a gap in the system and if you're talking about a whole of system holistic approach, then I think the attack on that side of the education system is important.

My fourth point relates to system governance and, if regional commissioning authorities are just LHN's or LHD's or HHS's, depending on our federated system and where you live, then I don't think that would be a forward step. In fact, I think it would be regressive. They're conflicted because they operate as both funders and providers and of course, there was the breaking out from Medicare locals to PHN's where PHN's are not supposed to be providers of services, but rather commissioners.

We haven't done the same thing at state level. They're conflicted in what they do. And as we know, in the time that they've been fulfilling their roles there's not been a significant shift away from the funders funding their own services to funding those organisations that may keep people well and thriving in the community, rather they - hospitals will always be at – having crises that's the nature of the beast.

And they will first of fund themselves. They will look after themselves rather than the community. So if you're talking about new structures, I think building on what the PHN's do would be a better way to go. I agree entirely with the principle that we should look as much as possible at funds pooling and joint commissioning, but I don't think we have a current structural vehicles in place to do that.

If you're looking at new organisations, I'm happy to talk about that. But I think at the moment, if we are trying to solve problems of federation through mental health then we might be at best dealing with a distraction or worse dealing with something that will be a waste of time and money.

One of the pillars of Contributing Lives, Thriving Communities, which as you know was the 2014 review by the National Mental Health Commission, and I was CEO and commissioner at the time, was that it integrated mental health into the broader health and social services system

some – it did not treat mental health as a silo even though quite frankly a lot of people at the time wanted that.

They kept saying, you know, that we're different, we're different you know, we need to be separate and yes of course, there are differences but good mental health and social and emotional well-being dependent on a holistic approach, not on silos and my concern about the rebuild model in the PC draft is that mental health is again set up as a silo which means it's someone else's responsibility when it should be everyone's responsibility. And I think we've seen that a bit in Western Australia with the Mental Health Commission in WA being a commissioner of mental health services where state health bodies have actually said well, that's their responsibility, that's their fault they didn't buy the right services, so you need to go and talk to them.

In addition, I think handing the funding and responsibility to the states appears to be potentially regressive in that jurisdictions are notorious for putting the welfare of their institutions ahead of the welfare of the whole community because that is what they are measured on. They are count – they are accountable for the performance of their hospitals. I think somewhat unfairly. I think states and territories are terrific at managing crises, even though there were obviously problems that appear.

But they do have that focus on their accountability for what they do and I don't think that getting states and territories to take that responsibility is going to actually encourage prevention, early intervention and all the things you want to do, unless there are mechanisms that are put in place to ensure that they do that. But I think they need to be broader bodies rather than just, as I say LHN's or whatever they might be.

So, my fifth point, one of the things I find very frustrating is that we – we should have a relentless focus on outcomes which drive selection of mental health performance indicators, but we actually often do it the other way around. We work out what's measurable and often it's activity. And then we say well, let's have a performance indicator that relates to that – things we can count.

It should be the other way around, we should be saying well, these are the outcomes we want to achieve, these are our targets, these are our goals, so what are the – what's the data that we need to measure those things and then pursue that?

And we don't do it. And we should be consistent about it, I mean, I get very frustrated by the way that we deal with performance indicators in terms of different age groups, I mean, you know, you've got National Mental Health Commission, AIHW reporting on age groups 18 to 64. I mean, what's an 18 year old got to do with a 64 year old? They do four to 17. What's a four year old like with a 17 year old or 12 to 24? A 12 year old and a 24 year old?

It doesn't make sense. And yet we know the data is there. I mean, they are trying to consistently measure naught to four, five to 11 or 12 to 17, 18 to 25, 25 to 34 and so on in 10 year age gaps. We can do it now. We just don't do it consistently. And then you've got different bodies that actually do surveying which is based on, again, different age groups. I mean, the National Drugs Strategy Household Survey was doing 12 to 25 year olds. They're

now going to 14 to 25 year olds. Why? There's no consistency there. So I think the approach needs to be reversed.

And my final point is about the vision thing. And you spoke about this at the end of the Grace Groom oration. And I think that what's missing is not the vision thing, but rather a coherent framework that ties it all together. It's the narrative. It's the narrative; the report needs to tell a story to those reading it about how life will be improved if the report directions and recommendations are followed.

And in the Grace Groom oration, you actually started to tell that story and it was good. At least you could sort of get the life span experience of 'Oh, well, at this time, I will get access to this. I'll need this. Et cetera.' And this is what will be there. In actually telling the story, I mean, you're talking about being person centred, early intervention, prevention, life courses approach, it's the right intervention at the right place and time. The importance of education employment, reform to the justice system and always with an eye to recovery. So if you flesh that out, if you provide the narrative which tells people what they should be able to expect and the very systems they will interact with over the course of their lives and how it will make their lives better, then I think you'll have the vision thing. And I'll leave it there, thank you.

PROF KING: Thank you. Let me just kick off a couple of small questions to start with. And then I'll pass over to my colleagues. You mentioned that the Western Australian Mental Health Commission, you said that you felt that it had sort of led to a re-siloing of mental health. If you've got any data, you know, if there's health documents or even news articles or anything you can point us to about that risk, it would be most grateful, because we do have the two options and we recognise that one of the risks of going down the Regional Commissioning Authority path is that attempt for that siloing. So that would be fantastic.

Data availability. You mentioned data, you said the data's there. But you didn't feel it was being reported in an appropriate or in the best way. One way to get around that of course is to say well, don't just simply rely on whoever's the data custodian at the NMHC. Let's say to report the data, but to make the data more generally available to trusted users, who will often be academics who will do what they do with data.

Would you support that sort of approach? The making in a sense, a data more publically available?

MR BUTT: Yes, absolutely. On your first point, yes. I'll come back to you on the WA Mental Health Commission. ON the second one, the – I mean, we've – I've done work with the Australian Institute of Health and Welfare who say, 'Oh, yes, we've got that data, we just don't publish it.'

There's a heap of it. I mean, they can generally do most things by age, although sometimes there's confidentiality issues. But they can do it by age, you know, four, five, six, seven, eight.

Absolutely, making it publically available, I think, is a terrific thing. Some of it is publically available now and they just – it's not asked for. So they don't publish it. So yes, definitely.

PROF KING: All right. And last one from me. Just on the Get Growing program.

MR BUTT: Yes.

PROF KING: For those groups again, mutual sort of – when you mentioned volunteer, I take the point there of – I guess where you talk about peer to peer support, it's a mutual support type of approach?

MR BUTT: Yes.

PROF KING: I wouldn't call that volunteerism, though.

MR BUTT: No, I wouldn't either.

PROF KING: That's right.

MR BUTT: Thank you.

PROF KING: Yes. But on the Get Growing, the – is there an issue of stigma around that group or a potential issue of stigma, if you have a mutual support group in a support setting, you know, do the kids risk getting labelled if they go to mutual support group by their – the other children or the other people in the school. How do you get around that? How do you – how do you make sure that stigma doesn't keep people away from those groups?

MR BUTT: Yes, I understand your point. I think it's the approach that you take. I mean, you're not talking about it as a mental health group. You're actually talking about how you actually support each other in the school setting, develop mateships. You talk about the fact that you've got – you may have all sorts of problems. I mean, they may not be just mental health problems, but they will lead to mental illness if they're not dealt with early on in life. So it's actually about not labelling it as a mental health thing, it's labelling it as a, you know, Get Growing. That's actually, look, how you can develop your life and work together and support each other and understand that if you've got problems, that's common. I mean, everyone has problems. And it doesn't matter what you've done in the past.

So, yes, there's a potential for stigma in it if you actually label it as a mental health program, but we don't.

MS ABRAMSON: Thank you. Thank you, Mr Butt. I've got two questions. The first one is a governance issue. You support more funding as I understand it. But you don't want any more control to the states and territories. So I'm just interested.

MR BUTT: I'd actually rather that if you were going to – you could develop a new entity which has got joint Commonwealth State Territory, consumer carer service provider governance. That's fine. But again, you're going to a – I mean, I think the question you've got to keep asking is what are you trying to resolve and why? And then you go to how you resolve it. And I think a structural response is not necessarily needing to be on the table at the moment. But I would say that the PHN's would be better placed to do that than the states and territories. I mean, I'd rather the funding went to a changed body of PHN's which are more

community led rather than state led bodies, which, as I say they've got conflict because of state and because they run hospitals and they've got to look after their hospitals.

MS ABRAMSON: Yes, but how would you improve? I mean, we've heard that the PH – in some PHN's work very well with their local health and others don't.

MR BUTT: Yes.

MS ABRAMSON: So the Commission really came from a structure to force a particular, you know, a commissioning body that was more responsive. So I guess that's what our thinking was. So any thoughts you had on how the PHN's and the LHN's or whatever the acronyms, commenced work together, would be really helpful to us.

MR BUTT: Yes. I think you can put greater accountability on their joint commissioning. I mean, I think you'd take a bit of a stepped approach. I mean, you build the platform and then you add to it over time.

I think you have to give greater accountability for them working together because I agree with you. I mean, some PHN's are performing really well, some are probably not as well-performing. Some of them I talk to, they have great problems with the LHN's they deal with or HHS's in Queensland. You can go to one PHN which will have a fantastic relationship with one of the, say, two or three LHN's in their area and they'll be saying, 'We're doing this joint planning, we're co-commissioning, we're co-designing with consumers and the other one won't talk to us.

So I think the accountability needs to be improved in relation to how they work together. Over time, I would be saying that the PHN's need to be strengthened and if you're going to invest more in them, then I expect Federal and State Governments to want – wanting to have a greater say in their governance. And I think that's not unreasonable. But I think to start again, and establish new Regional Commissioning Authorities, another layer of bureaucracy which will take probably years to get through State and Territory Governments and the Federal Government and I just wonder whether in the medium term, that will just be a distraction.

MS ABRAMSON: Thank you. Can I also ask, the states currently focus a lot on hospitals. So how could we get them in the model we're talking about to focus on community services?

MR BUTT: Yes. The only way to do it would be to be very clear about apportioning funding, to say that this will be spent on hospitals. This will be spent on the missing middle if you like. This amount would be spent on prevention and early intervention, which are often the same thing anyway. So the only way to do it is to be much clearer about where the funding is going to go because we know from history over decades that whenever there is a crisis it'll go back into the hospitals.

MS ABRAMSON: Thank you. I've just got one final question if that's okay. Were you very concerned – I was very interested in your Get Growing program. We're most concerned about students who fall out of the system entirely. So I'm just really interested. You did give in part of your evidence, you said that some of your lived experience, people said to you well, actually, if I'd had that in school – and you gave some evidence as well, which was some kids will come to school to do the program.

MR BUTT: Yes.

MS ABRAMSON: So – and you can – happy for you to take on those, but we are really, really interested in any ideas as to how we can keep kids in education.

MR BUTT: Yes, very happy to provide you with further information on that.

PROF WHITEFORD: Thanks David, so just going back to the – the Regional Commissioning Authorities. So with that, if we are going to pool the money, which you've supported, and both the Commonwealth and the State have a stake in this, was I correct in what you said that the level of government which has most, I guess, perspective or interest in population health as opposed to paying hospitals, might be the Commonwealth through the PHN's and therefore giving – giving that as the plank would be more likely to putting it under the states, and then we'd need a legislative base as opposed to create those Regional Commissioning Authorities, which in the report, we say should be using state legislation to create them, even though the governance doesn't have to be State Government.

MR BUTT: Yes, absolutely. I think it's, I mean, the population health focus should be coming from the Commonwealth and I think the Commonwealth should take greater responsibility for the missing middle issue of how you'd provide specialist in community services that keep people well and out of hospital. Because the states have not done a good job of doing that because of the – because of the, you know, different pressures and as I say, their performance requirements. Even then, though, you've got – so yeah, I think it should be a Commonwealth led thing, but you know, you've got inter-jurisdictional bodies like the Australian Commission on Safety Quality and Health Care which is governed by Commonwealth and States and not a bad model, quite frankly. That works very well.

But even then, I mean, you're still not – you're not including in the bucket as far as I know, and I might be wrong about this, MNS and PBS, which are big factors in driving the system. And I know you talk about that with better access, which I think is a good thing because I think better access isn't necessarily providing better access and it's very badly distributed in terms of where people get access to it and the old ATAPS of course, used to be there to try to fill the gaps.

So I think, the Commonwealth is probably the best place to do it, because you're probably not going to turn around Medicare and the PBS and start fund pooling much of that at this stage. Although, in the longer term, it may be that you can do that. And ideally, you would.

PROF WHITEFORD: All right. Thank you.

MR BUTT: Thank you very much.

PROF KING: Now, the person we were planning on having next cancelled at the last minute. Normally much later on in the day, we would ask is there anyone who hasn't actually formally registered or presented evidence elsewhere who would be interested in talking here. And I will do that also later on in the day, but as we have a short gap in our program at the moment, is

there anyone who didn't register formally to speak, hasn't spoken at one of the other hearings who would be interested in talking to us now?

Yes? If you would like to, please. If you can come up, state your name, if you're representing an organisation, the organisation and what you would like to say.

MS WILLAN: Hello, my name is Helena Willan. I am here as an individual with a living experience of mental ill-health. I also am the mother of a 14 and a-half year old son. As a parent living with serious mental illness, I have really noticed that the communication for parents like me with a child where I wanted to access specialist mental health services for my son, that has been really difficult.

I would have liked to have been able to access Headspace services for my son, prior to him being 10 years of age, because we have had extremely complex family circumstances where that was highly valid. I have been concerned about the safety of reaching out for support for my young child at the time and our family because of the extreme prejudice sometimes in the provision of psychiatry services and the discrimination that I have faced over the last 20 plus years in receipt as myself.

Because of some of the traumatic hospitalisation experiences and other community experiences, as a person living with serious mental illness myself, this has caused me valid concern as a parent, trying to access services for my child where I have wanted those services to be both safe and of quality.

That is made more difficult because there has been a misunderstanding I feel, by professional services and the sector that parents with serious mental illness like myself will be not open to having their children receive services, whereas I have felt exactly the opposite and then wanting to actively reach out. So when my son was experiencing symptoms that were quite serious and he was really quite young, I wanted to access specialist services for him and I did make some preliminary, tentative, careful inquiries. And the signalling I got back was that it was most certainly unsafe for our family, for me, to do that.

So I had to actually make a very difficult decision as a mother to manage the situation as best as I could without accessing those specialist services. That is a decision that I would really want any parent with a serious mental illness or not, not to have to make. We should have a system that is safe, that has quality services, that are transparent, that are advertised on the websites and that there's active outreach and engagement with parents and not a presumption that we don't want these services for our children.

Particularly, I'd like to say, as a person with over 20 years of lived experience of serious mental illness, and being a parent for 14 and a half years, I also do have a university degree. I think that sometimes there is a presumption of a lack of intellectual conceptualisation and understanding of these issues and, also there are discrimination issues about parents with serious mental illness lacking the insight to want better for their children, to understand these issues. I don't feel that's really where the issues are. I think that we need to create a system, also, being very mindful of the crossover to child protection.

This is a really serious issue because I've had multiple involuntary treatment orders, and as just part of the process of being released back into the community, back to my home, as the primary carer of my child, it is just a normal part of that process to be assessed by child protection or in the back systems of my safety to re-take up that role. Unfortunately, that has been something that hasn't been transparent, and I think for my human rights and dignity – as a person, a citizen, formerly a wife, still a mother – that I have the right for that process to be transparent, at least to the best degree it can be.

I feel that the reports about all of that should certainly be written in a way that, if they can't be provided to me on discharge, that they should be written in a way that I would be allowed to have access to them in the future, and that there would be a process of, well, we want our patients to have access to those 12 months later, or, you know, when then is a recovery needing to happen, and maybe that could be quite distressing at the time, to read it, and not necessarily appropriate. Because what happens is, my authority in the family has been usurped. It's caused a great deal of distress to my family carer, of my aging parent, my mother, my child's grandmother.

And it really effects the family structures, and my valued social role being recognised within the family that I was the wife, I am the mother, he's my child, I'm the decision maker, or in a normal family situation, that would be the case. So, thank you.

PROF KING: Julie?

MS ABRAMSON: Thank you. Thank you very much for coming to share your experience with us. I think Stephen's asked because I'm the lawyer on the – on the panel, I'm very interested with this interaction with child protection services. We have said when people appear before a mental health tribunal we're very strongly of the view they should have advocacy support, whether it's a lawyer or somebody to support them. So I'm just interested in unpacking a bit more your comments about what would have made a difference. I heard what you said about transparency of reports, but just interested in understanding that a bit better.

MS WILLAN: There is a – there is a real lack of acknowledgement, like I have gone through a divorce with an under 18-year-old child, and I live with a serious mental illness, and I have found it really problematic, accessing justice in the family law area.

MS ABRAMSON: Yes.

MS WILLAN: It's something that even now, with custody issues, I have ended up not taking it to Family Court, and I've allowed a situation – what I meant to say, I'm too frightened to access what would normally be my normal citizen rights - - -

MS ABRAMSON: Yes.

MS WILLAN: - - - and my normal rights as a mother to go to Family Court, about a situation with my son. Because of my history as a person with serious mental illness, for over 20 years multiple involuntary treatment orders, and therefore, multiple assessments by child safety. That doesn't look good, and in the courts, all the lawyers and the courts are designed in a way

to view a history like that, really, only negatively. There's not enough engagement with people with serious mental illness that we're actually just ordinary people. I'm just an ordinary mother. I'm very boring; there's nothing interesting about me, and my son will attest, I am a homework dragon. You know, like - - -

MS ABRAMSON: You share that with other people.

MS WILLAN: Yes. There's nothing of any real note about me. I'm incredibly ordinary. Unfortunately, trying to be ordinary is made extra-ordinary for me, because of my circumstances, and my lack of ability to access ordinary things like safely access a Family Court. And I will say, in the lead up to the design and authorisation of the Mental Health Act 2016, here in Queensland, there were some last minute changes that came from the legal establishment of the courts here in Queensland about how they wanted to have some things to help them manage mental health patients, and the treatment authorities and different things, and I felt, as a consumer, that that was evidence that, well, how are they going to feel, and think about me, as a person with serious mental illness, in situations like I'm trying to access justice for family matters, and frankly I'm afraid.

And if I ever get a letter for jury duty, which I haven't yet, I'm actually going to write a cover letter and get a letter from my GP to say, well, I'm too afraid to access justice for myself, and – and frankly the system keeps telling me I lack insight, and am a person of permanent unsound mind, despite the fact I have a degree – I have obtained since diagnosis, so please excuse me from jury duty until you fix all of these issues. Yeah.

MS ABRAMSON: It's a very - - -

MS WILLAN: It's a very indirect answer to your question. I apologise; I hope that does make sense.

MS ABRAMSON: No, no. It's actually incredibly helpful, because to be honest, you're the first witness that's spoken to us about a family law issue, which is related to the mental health tribunal, because our focus has been on the mental health tribunal. I'm not a family lawyer, but it's very interested evidence, given that the rights of the – or, you know, the child's view is actually quite an important, and what's best for the child, so that's been very helpful. Thank you.

PROF KING: Can I just – can I ask what services – for your child, what services, if you're able to say, did you feel that you couldn't access just because it would put, potentially, create a threat for the family?

MS WILLAN: Because of, really, the blanket silencing.

PROF KING: Yes.

MS WILLAN: So, because of the blanket lack of transparency, this blanket sense that parents such as myself must not want our children to access services, and therefore there being a bit of a potentially cloak and dagger campaign of how do we access these children to provide them services, we need to go behind the parent's back because they wouldn't possibly be welcoming

of it, which is, in my case, exactly the opposite. As long as they're safe, quality, transparent, and I'm engaged within a way so that I can actually, as any normal mother, feel a sense of confidence in the competency of the staff, and the evidence base, or at least proof of concept of what's being used for my child.

My son has a very high risk of serious mental illness because of my genetics, and everything that we can presume. The other side of his bloodline also has, not of his father, but the father's brother, completed suicide at age 19, and he actually spent his 16th birthday in the Barrett Centre, so there was a long history there, and with some cannabis use, which I have strongly advised my son prior to beginning high school, of his risk, and to avoid illicit drugs, and I have explained very clearly why.

So, the fact is, we need to be getting to these children well before 12 years of age, and headspace. Children like my son must be educated, as they're growing up. I want to engage with professional services, especially for the education component around do not do illicit drugs. It's not safe for you. One psychosis is one psychosis too many, and it will trigger a genetic repetitive condition, which is extremely regrettable, and we can avoid a lot of this harm, and this group of children that deserve better lives.

PROF KING: Yes. Is your son now accessing services through headspace, and if so, how have you found that as an effective gateway, or ineffective gateway?

MS WILLAN: As a consequence of the divorce, and a challenging – all the challenging repercussions of that, and my inability to go to Family Court because of the deep concerns I have about legally being prevented from being as much of a small influence as I'm able to currently be, I have only been able to talk, informally, with my son, and advise him of our local headspace, which is within one bus trip for him, it's easy for him to access independently. We, as a family, had arranged for him to be seeing an excellent, private child psychiatrist, which I – it was very expensive for us as a working class family, but because of, again, the trauma I experienced, and my very deep concerns, I was not prepared to go through the public system, because it lacks transparency; it lacks that ability for me, as a mother, to actually see, is this quality, is it safe, what's the competency of the staff. Whereas paying a very expensive private child psychiatrist, I was able to actually check that.

And he was excellent at diagnosing my son. I do have a different surname, so I am able share, with respect, in my son's privacy, my son's diagnosis of Attention Deficit Hyperactivity Disorder, and anxiety. As a mother, I also feel he has depression, and I am aware he is at high probability of developing much more serious mental illness, if he's not given better services, which he's as far as I know, not quite getting. So he's on Concerta 36 milligrams, every morning, which I am aware he's not regularly taking every single day, where he's living, and I am, again, informally having conversations with him to encourage him to make a decision that might be more supportive of his education. But that is something, at 14 and a half, and living full-time not in my household, I have little practical ability to influence.

So, he knows headspace is there, at Nundah, and I'm encouraging him, and I'm saying to him, our financial circumstances, as a family, are really difficult. That's a really positive way that we can't afford the private child psychiatrist and the other parent has been preventing him from attending, because of things to do with family law. So that's not good for our son's health; I'm

very concerned. But I've given my son as much informal advice as possible and I believe the children can have their own Medicare cards from 15 years of age, and I've been talking to my son about, 'Make sure you get your own, independent Medicare card from 15.' That's in six months for him, approximately, and I'm really keen for him to take full responsibility for his own mental health care, and letting him know I'm there for him, if he wants to. Yeah.

I would like headspace to take children in this group much, much younger. I actually, strongly, feel accepting children from 5 years of age is not too young, in this group, because there are real issues I would have appreciated help with, and it would have improved the mental health of my son, and if it could have been made safe, that would have been really good for our family, for my child. And I do feel that headspace, because a lot of families are under economic pressures.

PROF KING: Yes.

MS WILLAN: So I feel that's very important consideration.

PROF KING: Okay. Anything?

PROF WHITEFORD: No, that's fine. Thank you.

PROF KING: Thank you so very much. Thank you. Next, Tony. No sooner in than up. Tony, if you'd be able to state your name, the organisation you're representing, and any opening comments you would like to make.

MR STEVENSON: Thank you. Tony Stevenson, CEO with the Mental Illness Fellowship of Australia. Thanks very much for the opportunity to speak this morning, and I really do want to acknowledge the willingness of the commissioners to engage with discussion, very, very widely. I'd like to acknowledge the passion that you have to make this system much better. And willingness, of course, to continue to look at – at all of these very complex issues, and come up with a very good result. So, thank you very much for the work that you've done.

MIFA is an organisation, it's a federation of long-standing member organisations established in 1986. We have seven organisational members across Australia. We support about 20,000 people each year. Our members formed at the time of institutional reform. Family members and people living with severe mental illness coming together to support each other, at the time when people were now being returned to the community, and advising government, and lobbying for appropriate community services. So, we have a very deep interest in support for people with severe mental illness.

I just wanted to focus today on psychosocial support, and then leading into workforce issues in relation to that, and then make some comments about funding and commissioning as well. The number of people with a complex – with complex care needs, according to the draft report now, is noted at 350,000 people, and the report also notes that between 190,000 and 250,000 people with episodic or persistent severe mental illness, have significant, complex needs arising from their illness.

Modelling for the NDIS estimates that 64,000 people will be eligible for the NDIS. That's between 25 per cent and 33 per cent of that group with significant complex needs. But at the moment, only 28,000 people, or between 11 and 15 per cent of that group, are actually receiving support through the NDIS. A number of people are getting support through programs outside of the NDIS, so I estimate that to be around, about, 30 to – well, probably about 30,000. Ten thousand people are still in commonwealth funded transition, and (indistinct) support. A further 3,000 in the commonwealth component of the national psychosocial support measure, if we assume about 20,000 people are in state/territory programs, then including the NDIS, we've got about 60,000 people receiving psychosocial support, either through the NDIS or outside the NDIS.

So I guess, and excuse me for going through all those figures, but I think that means that we've got a current level of unmet need for psychosocial support. Perhaps in the order of 130- to 190-000 people. So, what we believe we need from the Productivity Commission, is up-to-date and accurate data about the demand for psychosocial support services for that cohort, and we recommend that the Productivity Commission provide an analysis of the expected demand for psychosocial support services; the extent to which that demand should be met through the new system, and the estimated future investment needed in psychosocial support services.

My next point relates to the scope and nature of psychosocial supports. The model of Stepped Care, on page 18 of Volume 1 of the draft report, includes psychosocial supports as part of the complex care step, and page 25 states that even with the best clinical treatment, episodic or persisting mental illness can result in the need for psychosocial and other supports, such as a combination income and vocational support. I think that employs two things, and I know we've had this discussion several times, Stephen, and thank you for continuing to engage in that discussion.

But what that implies, I think, is that psychosocial supports are secondary to clinical treatments, and that psychosocial supports are limited to social and community supports, such as stable accommodation, income and vocational support, as used in that example. We need a better understanding of psychosocial supports. They're critical for a person's recovery on a number of levels: on a person level, psychosocial supports are a necessary precondition to the effectiveness of clinical care; psychosocial supports provided by a trained and experienced support worker contribute to a person's understanding of their individual strengths and resilience; psychosocial supports build on a person's hope and optimism, and empower people to have agency over their own lives, to understand that they have choices and to exercise control over their lives.

That component of psychosocial support, I don't think, is reflected in the report. And that's very well outlined in the national framework for recovery oriented mental health services, a Department of Health publication in 2013.

So that's at a personal level. At an interpersonal level, psychosocial supports build relationships with family and friends. These relationships are often fractured and people can become isolated. Without support from family and friends, clinical care often fails. There's also now an emerging concept of relational recovery, which points to family or social relationships as central, decisive determinants and enablers for recovery. It places the focus of deficit and

therefore the focus of intervention in the space between people and their social environment, rather than the space between their ears.

It's primarily community focused, has family life at its heart and deals with the real world. So we've got the personal and interpersonal aspects of a recovery approach or psychosocial support, if you like. Then you've got the community level psychosocial supports which connect the people to stable accommodation, income, vocational support, connect people into clubs, social activities and other activities that lead to social inclusion, participation and contribution to family and community life.

I get the feeling that when the report and when the discussion turns to the fact that psychosocial and clinical support are interdependent housing – I'm quoting you again, Stephen, housing and employment will fail without the clinical care. I actually think it's the other way around, the clinical care will fail unless the psychosocial support is there. It's not just the support that connects people into the other social determinants of health, if you like. It's that personal and interpersonal support that happens, building relationships, building the strengths and resilience. It's a difficult one to define.

When I ask support workers what do they do and why is recovery effective, they say, 'Well we don't do anything, the person does it all', you know, there's a sense that psychosocial support within a recovery framework is invisible because it's not the thing that is – for a good recovery worker, it's not the thing that they put down to a person's success in their recovery process. They believe that's because the person's doing it themselves. But of course it's that skilled work that happens very gently and very subtly along the way that supports that person to take those steps.

So psychosocial supports are essential to recover, it's not an add on to clinical care and not simply concerned with the domains of the social determinants of health. And you do say in the report that there is no coherent psychosocial system and we agree with that and we need to get that into the system. But it needs to be firmly embedded within a recovery framework and, as I said, an emerging concept of relational recovery.

In fact, in that Stepped Care Model on p.18, there's a reference to psychosocial supports in the step for complex care. I think that should be amended to reflect the notation of clinical care which is much more expanded to something like – so psychosocial supports provided by qualified support workers and peer workers within a recovery oriented framework.

If I can turn to the person centred approach and if anything that is the most refreshing aspect of the whole report and as you, Stephen, have spoken very passionately about this being person centred and person (indistinct). So we have a Stepped Care Model which is useful for systemic planning purposes. The five steps, the characterisation of people's complexity of mental health issues and other issues is very helpful for planning purposes at a systemic level. That's why I'm proposing that of the complex care group of 350,000 we are now in a position to be able to understand what is needed in relation to that group particularly for psychosocial support.

So for planning purposes it is a great model. But it's not a model for understanding how a person gets access to the system. That has to be an ecological model – person centred model and there are many around but that is not currently in the report. A person centred model, the

person at the centre, their family and friends and so on around them – well initially their strengths and resilience and capabilities, family and friends, you have then their interaction with psychosocial support services or clinical services, and with specific community services that will support people with mental health issues, housing, employment, justice, all of those. Then just the general community itself, access to sporting clubs and other activities of interest.

So ecological system, with the person at the centre. We don't want people running up and down steps, as they get well or unwell and they have to now convince someone that they're in a different step and therefore they have access to different types of services. The person stays exactly where they are, the system changes around them. So it's reaching out, so you might reach deeper into the housing part of that ecosystem, if you like. Where after spending time in hospital having lost a tenancy as a result of that, then housing becomes probably the most important issue for that person. So you're reaching out deeper into that. You're getting more support in that housing outreach from the individual and so on, and that changes according to the situation that the person is experiencing at any given point in time.

So we are recommending that the Productivity Commission review the personal centred models developed. The number of PHN's developed those models, there are other models around and a person centred model as you have a Stepped Care Model, a person centred model in the report. I think that's where we fully integrate support from families, carers and friends as well.

We're concerned about the fragmentation of individual support services and support for carers, if you like, as a general term. But that does need to be integrated within that ecosystem given that for a lot of people, family are their first call and we certainly see that as a goal for all or most of us to be connected with our family. So as soon as that becomes a different system or a different part of another system then it starts to get fragmented. It needs to be considered within that person centred model. Sorry, I'll finish up soon.

Workforce. So we see the need to develop skills and properly remunerate the workforce in the provision of psychosocial supports. I think it's a concern whether it's the spotlight on aged care or disability services, mental health, we are at risk in Australia of potentially our largest workforce becoming our most unskilled casualised and low paid workforce. It can't be good for the economy.

So even just for an economic perspective we have to look at the, you know, adding skills to all of those workforces. But as I've mentioned, psychosocial support is a very skilled area. People may not have the four year degrees of a psychologist but what they provide is equally, and some would say more critical to a person's recovery. As I said, as a precondition to enabling that person to fully engage and get the most out of their clinical care. Because we don't have that objective recognition, if you like, of that profession then a lot of things fall off. You know, we think that we can pay them less, provide funding mechanisms that entrench casualisation of their workforce. We wouldn't think about it in relation to therapists and other four year qualified people in the health sector.

So, I made couple of points earlier about understanding the demand for psychosocial supports, and the skill required. So those two factors must influence the workforce planning around the psychosocial support workforce, which includes the peer workforce, of course, and thank you for highlighting the peer workforce in the report.

I'll just turn to the financing and commissioning. Of course we agree that there does need to be a national agreement for the provision of mental health services, and that funding model should provide incentives for the states and territories to invest in community-based mental health services. And you make the point, and I agree, that the states are the level of government - states and territories - the level of government that is responsible for the high cost services of acute hospitals, prisons, and homelessness services.

So the funding arrangements for mental health must shift the thinking of state and territory governments, so a heavy financial incentive to invest in those areas, and you have already identified that. We believe that that national agreement should provide an additional investment for community-based psychosocial supports, and again, to ensure that there is no capacity, if you like, to shift the funding away from those community-based psychosocial supports into clinical care, which is where the states and territories have their traditional interest and their major stakeholders.

There is confusion of Commonwealth and state, territory responsibilities, and you have proposed a solution to that, and that has given us all the opportunity to think about how we should structure the commissioning and direct funding administration. So assuming we have a national agreement that I've just outlined, then how should that be administered?

The first point I'd like to make is that we do support the regional commissioning concept. Not the RCAs at this point, but a regional commissioning concept. We think that a region needs to be regional enough to be relevant to its unique needs. So, as an example, we have a PHN region in Queensland which extends from the Sunshine Coast to Rockhampton. That is not a region. The needs of the Sunshine Coast are quite different to the needs of Bundaberg and Gladstone and Rockhampton.

So, to get the best out of a regional model, it must be regional enough to take account of the regional needs, and that could be done through rolling up a number of regions, if you like, into another unit that gives some efficiencies, and so on. Regional commissioning, we believe, is the best way to solve this problem we've always had, which is how do you make a system work for rural and remote communities, for Indigenous communities, et cetera.

Well, if you plan at a regional level, if you get the region involved, then you're going to have services that are going to be relevant to those regional areas, and you're also going to bring in to that all of the regional resources, capabilities, innovations, the people, the leaders, the social infrastructure within that region. So we strongly agree with having a regional process.

PROF KING: Just, we're at time, Tony, because we'd like to get some questions.

MR STEVENSON: Okay, all right. Starting a new system, state, territory run regional commissioning authorities; not sure that it is the way to go. But I don't want to close off that option at this stage. I think we just need to do more work around it. But what I would like the Commission to put up as a - perhaps another option is a sort of a hybrid model. So you've got your state regional authorities, LHDs, whatever. You've got your PHNs.

So something that might look a bit like a collective impact model with a backbone, with major

shareholders being the state and territory government regional group PHN, the community, the carers and consumers, so that there's a structure that brings all of those interests together into a backbone, which means that governments can channel their money through their existing regional authorities, but the backbone is the governance body that then brings all that together.

So a very strong structure that makes sure that all of those factors are brought together in this other - in this sort of collective group, if you like, then to then understand, through the regional planning, what the needs are to bring all of those resources together to decide collectively how that makes sense for that community in a way that prevents duplication, overlap, gaps, messiness of knowing who's responsibility it is, et cetera.

So that's just another option to think about, and that's where the consumer carer co-design is embedded. So that needs to be absolutely embedded at the regional planning and community level, and having consumer and carers as part of that collective governance group, I think is one way that that can occur. Thank you.

PROF KING: Thank you. I'm going to start with your last point, because - okay, so you've got your backbone organisation with state and territory representation, consumer carer representation, PHNs represented for the relevant area. That group would have to have control of the funds, I assume?

MR STEVENSON: Yes. Yes. Well, control of how the funds are used.

PROF KING: Yes. So, I mean it would have to be able to say to the state government, you're not going to be using that money for acute beds.

MR STEVENSON: No.

PROF KING: You're going to be using it for (indistinct).

MR STEVENSON: The state government is part of that group. They decide.

PROF KING: I understand, but that group has to be able to make decisions that bind the state government.

MR STEVENSON: Exactly. And so the state government needs to bound to those - to that collective decision. So they're operating as part of a collective. They're bringing their own resources and their commitment, and should the government come up with a different way of understanding the roles and responsibilities of the Commonwealth and the state in such a way that the Commonwealth and the states bring their particular remit, if you like, and their resources into that collective decision-making process, then they're bound by the decisions of that collective.

PROF KING: Yes. Okay. So I mean, the key, it seems to me, is that it has to be that control of the funds. Otherwise, the body can make any decisions it likes.

MR STEVENSON: Yes.

PROF KING: The states and Federal government will just do whatever they like.

MR STEVENSON: Yes. A very subtle point; the body has control of those funds, but the body is made up of - - -

PROF KING: I understand, yes.

MR STEVENSON: Yes. Yes.

PROF KING: It's just it's not that far away from what we've called an RCA.

MR STEVENSON: Yes, true.

PROF KING: Yes, okay. Data. You mentioned it would be great to be able to do the demand on psychosocial supports that you need, albeit you suggested that we should do, but to do that, we need data. So I guess, just a question for you in your role with Mental Illness Fellowship of Australia, we can only do that analysis if we get the demand data from the individual not-for-profit, because the not-for-profits have the demand data. Are you able to provide us with that sort of data?

MR STEVENSON: Yes. I wouldn't say that we have all of the demand data. I think some of it is qualitative in nature, and I'm - it's quantitative, but it's also qualitative. It's understanding what's happening in the community. But I think where the data analysis has been done in the past, and that's looking at a population level, the percentage of people in different cohorts, and if you assume, based on the knowledge of what's happening on the ground, you extrapolate that at a systemic level or population level to then, I guess, inherent in the mental health services planning framework. That type of methodology.

And this is where, at a national level, there is a sense of - as the NDIS process came up with a target of 64,000 people with a psychosocial disability, it's coming up with a national understanding of that. Now that's applied at a regional level, and that's where you get the qualitative data, and the quantitative data from the service providers for the community then to understand, in relation to those national targets, what's relevant for that local region.

We're absolutely happy to share the data. We provided a lot of that data to the NDIA. The Optimising Psychosocial Support Project managed by Mental Health Australia, with MIFA and seven other national mental health organisations, contributed all of our data into that analysis, and we're happy to do that.

PROF KING: Okay, thanks. Harvey?

PROF WHITEFORD: So thanks, Tony. There was a minimum data set that was developed some time ago, with the expectation that there would be some collection of what services were provided, because I guess you need both the demand side and then what - how close are we to meeting that demand.

MR STEVENSON: Yes.

PROF WHITEFORD: But now we've been told it hasn't gone as far as it should. Some states are collecting it, others aren't collecting it.

MR STEVENSON: Exactly.

PROF WHITEFORD: Can you just give us some insight into how you see that from your perspective?

MR STEVENSON: Yes. Well, it's not working. Yes, it's not being implemented nationally, and we just don't know where that information's going.

PROF WHITEFORD: Because? Any idea why it's not being implemented nationally?

MR STEVENSON: The perennial problem, and I know you're all aware of it, an organisation that is concerned about a group of people and the support that they're providing, in order to do that work might have six or more funding streams coming in. Each of those funders wants certain data, and the national dataset is designed to harmonise all of our data, of course. They require particular data systems. PHNs require that we use their data collection system for their funding, whereas the organisation might have a different data collection system, or client information system.

Getting those systems to do what everyone wants them to do is almost impossible at the moment. For an organisation to do what its primary mission is, to understand what it's doing in relation to its people that it's supporting is very difficult, because the data is collected according to what the funder wants. So they've got to try and harmonise that at an organisational level as well. So I think they're some of the reasons why we're not getting that data.

What we did with the Optimising Psychosocial Support Project was that I think we collected something like 20,000 units of data. That was filtered down to about 13,000 units of what could be compared and analysed. But that was a huge task for that one particular project, to do that work.

MS ABRAMSON: Could I ask you, Mr Stevenson, about the workforce. One of our issues is that when we look in from the outside, we can see clinical services pretty clearly.

MR STEVENSON: Yes.

MS ABRAMSON: But it's the nature of the workforce where it's a bit opaque to us. We had some very helpful evidence, I think, from the Australian Services Union, so any evidence or support that you can provide us - who does what, and where they do it. Especially, you also talked about some of the support being - I can't remember your exact words, but you said, 'person themselves does the work', not the - - -

MR STEVENSON: Yes, yes.

MS ABRAMSON: Yes. So we would be really grateful for, in a submission, which I assume you're making, if you could provide us with some more information about the workforce.

MR STEVENSON: Yes. The workforce is invisible.

MS ABRAMSON: Yes.

MR STEVENSON: If you look at AIHW reporting, community mental health, in the way we understand it, is not collected in that data. Community mental health means hospital based or state health departments' community mental health. So we don't have that data. There's no single accreditation body, such as the Australian Psychologists Association or other group, that people are a member of, and in fact, we've decimated the workforce. We've casualised it.

We have people who were on a particular level under PHaMs contract are now one or two levels below that, on a much lower wage. So we really have lost a lot of ground in Australia in terms of providing that genuine psychosocial support compatibility, and the NDIS has been the catalyst for those changes.

MS ABRAMSON: Well we would certainly welcome you giving us some more see-through of that workforce in the submission, including any of the data that we spoke to previously. That would be very helpful. Thank you.

PROF KING: Okay. One that I would just put on notice. It's along with the workforce data. We'd be interested to get your feedback, but I won't ask for it here, just because of time constraints. One of the things that's been pointed out to us is that whilst we took the psychosocial supports in that far right column, that there are actually individuals who their clinical needs may be much more modest, if I can put that way, but may need a lot more psychosocial support. So perhaps people with hoarding disorder, OCD, those sort of things.

So I'd be very interested in getting your thoughts on that, but as I said, our time has run out on us now. Also, one of the other things that's been put to us, exactly on the lines of that interaction between clinical and psychosocial, to what degree should consumer choice allow, well, actually I don't want the clinical supports, I just want the psychosocial supports, and we want a consumer centred system, we want to enable consumer choice; to what degree does that provide the clinical psychosocial support menu, and should there be any constraints on that from the consumer point of view?

So should it be the case that a consumer can say, well actually, no, I don't want the pharmacological, or actually, no, I don't want the face-to-face or the therapeutic. I need the psychosocial supports and perhaps some peer groups, some peer support.

MR STEVENSON: And I think you have just answered that question about the value of psychosocial support, and look, I don't want to detract from the agency of any individual person making their own decisions, or on the role of family and friends in being the first port of call for people to help make those decisions. What I can say is that a skilled psychosocial support worker, or a recovery support worker, does exactly that. They fill that void. And if I can just give a brief story.

PROF KING: Just very briefly, because we have - yes.

MR STEVENSON: Yes, yes. A person who might present to an NDIS planner, in terms of their goals might talk about that they would love to be able to go to the movies every Tuesday night. And so, very quickly, you can see they've come into a package. There's a bit of transport, a support worker, level one or two casual worker going to that person's house, taking them out to the movies and bringing them back home. Did that person ask for a more complete vision about their life? I don't think I could do that.

But what a qualified and skilled psychosocial support worker could do in that scenario is that they would meet with that person, they might take them to the movies for the first couple of weeks, but the incidental building of trust, understanding where that person is in terms of their goals, what other supports they have. So slowly, and over time, there's a trust being built up. There's a deeper understanding of that person and their goals, and in the best scenario, after a year, that person would be much more comfortable leaving the house, and leaving the house on their own.

They would know how to use the internet to find out what movies are on, to know when the bus is due to pick them up. To be able to budget to go to the movies. To perhaps have been in a situation where they've met people. They've developed friendships. They've got a group of people to go out to the movies with.

Now that is what recovery would do. That's what a recovery approach and the skilled psychosocial support worker can do. If you leave it at a certain point of a plan or a person's understanding of their goals, forever, they might need someone to come and pick them on a Tuesday night and take them to the movies, so - and particularly the role of a peer worker, and it's very gentle and it's very subtle, it's very, you know, difficult to necessarily understand what's happening and how it's happening. But when a person who's saying, "No, I don't want to do that. I don't want to do that. I don't want to do that" and the they see the experience of that person, that peer worker, coming through it may give them the confidence, the hope and the optimism, because it does start with those very personal issues for people to start thinking about taking steps, you know, and taking agency and taking greater risk and so on.

Now, you know, again I'm doing what the support worker would say. Don't think that that's a worker glorifying their role or talking up their role. They would say the person does it, but there's a very skilled process that goes along the way.

MS ABRAMSON: Mr Stevenson, could you take on notice and have a real think about this for us about criteria for accessing services because, you know, when we think about some of the previous programs, we've had PHaMs and Partners in Recovery, there are criteria. So if we're going to - taking the model that you've spoken about, that would be a really helpful contribution.

PROF KING: Yes, but we will take that on notice.

MS ABRAMSON: Yes.

PROF KING: Because we do have to move on.

MR STEVENSON: Yes. Sure.

PROF KING: So thanks, Tony. Thank you very much.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Thanks, Tony. Thank you.

PROF KING: Next we have Vicki Hancock. Vicki is not here? Okay. Sorry, then Geoff Waghorn. Yes. If you could state your name. If you're representing an organisation, which organisation. Any introductory remarks you'd like to make.

MR WAGHORN: Sure. My name is Geoff Waghorn. I was previously employed by the Queensland Centre for Mental Health Research in Wacol. I have a PhD in vocational rehabilitation. I've worked as a scientist practitioner. I've conducted research in this field for over 20 years. I've published over a hundred - maybe 120 peer reviewed research articles in this field, and I'm very pleased to be able to be here because I'm actually retired and working on my golf handicap. So this is something that I've always wanted to be able to do as part of my career plan and journey was to, you know, influence an important body like this in order to head us in the right direction, you know, as a country. Thank you.

MS ABRAMSON: We're very, very interested, as I'm sure you would have noticed, in the IPS programs.

MR WAGHORN: Yes.

MS ABRAMSON: And my very talented staff have a range of questions - - -

MR WAGHORN: Sure.

MS ABRAMSON: - - - if you don't mind, if I can ask you. One of the things that we're interested in is where we would conduct those IPS programs. So would you do it through a community mental health service? Would you think that there's another model, and also how you would remunerate for it? So just your experience, especially with the research you've done.

MR WAGHORN: Sure. Okay. Well that's a very good and practical question to begin with. The reason we looked first at state organised public mental health services is because that's the honeypot where the bees collect. That's where you find large numbers of people with moderate to severe mental illnesses. That's where you need to go to start with. You need to go and help those people because at the moment their only real prospects of getting into competitive employment are via exiting that agency and going to another agency such as, you know, the Disability Employment Service program or some other welfare linked program in order to get assistance, in order to, you know, get and find a job of their choice.

Some people do it on their own with maybe help from family or others, but there are skilled practitioners out there who specialise in this kind of support and contrary to what the previous speaker said this is not a role for psychosocial support workers. Psychosocial support workers

can't do employment. It takes another skill set to develop that ability. Usually two years of working in the industry or more and usually two years or more of following the right kind of practices. So, you know, there's a lot of people in vocational type services out there who are using the wrong practices. Who are doing nothing but damaging the career prospects of the clients they work with. Either providing too much support or not enough support or in various ways - not purposefully, but in various ways causing what we would call negative employment experiences.

And every time a person has a negative employment experience, it builds up huge issues to overcome the next time. So very skilled support workers are needed and, you know, with due respect to the previous speaker psychosocial support workers are not the answer to that. We need highly specialised employment support workers. We call them employment specialists, and they don't need to have a university degree. They don't need any specific personality profile, but they do need to be able to become client centred and to understand and pull apart the problems that need to be solved in the journey to employment. So it takes kind of an incredible problem solving ability and be able to see the world from another person's shoes. So that's why we start with community mental health, and what we like to do is imbed those workers in the mental health team.

And the reason we like to do that in the IPS program is because 20 years or so of evidence have shown that when that happens the mental health treatment gets better, the longer term care of the person gets better and it's much easier to control the funding of that because people aren't recycling through the mental health system over and over because everything is converging on the person's longer term goals, not their short term needs. The clinical team are often focused on the person's immediate care needs, immediate treatment needs, whereas what we really need to do to stabilise recovery is to establish the person in their own employment of their own choice and their own role in the community, and the amazing thing about this program is that once you start doing that with employment, you can then address every other goal in the person's spectrum of goals, psychosocial goals, because employment is the hardest one.

So that means if you can succeed with employment it takes a fraction of the effort to succeed with education and training, because there are universities and institutions out there ready to welcome students. It's not hard to link them up with the right institution but you've got to do, you know, some kind of audit on the qualification to make sure it has some link to some future job and some career path that is actually practical and then you have to, you know, mix that or match that to what the person is capable of doing right now, what they're inclined to want to do and what they can manage to do when they're not feeling well, you know, because they can do stuff when they're feeling great but when you're not feeling well you've still got to get to classes and you've still got to get to whatever you're doing. So I call that wraparound support or wraparound rehabilitation that wraps around nicely vocational rehabilitation.

So vocational rehabilitation becomes the spearhead and people who don't yet have an employment goal may have other important goals for their recovery which can then be picked up by psychosocial support workers and other members of the mental health team. You know, in the US some members of ACT teams, assertive community treatment teams, used to do this already and I'm sure you guys have heard of those teams. They were never implemented faithfully in Australia. They were always implemented in a fraction of what they were, you know, scope to do. But in those original assertive community treatment teams different allied

health professional members of the teams took on different responsibilities for different parts of recovery.

So some team members would become education specialists, for instance, or training specialists and another member would become an employment specialist and others would, you know, work hard to coordinate treatment and care or those things, you know, because it's really important in this kind of space to not have services conflict with each other or have gaps between. And the practical solution to that is to have it all coordinated through a treatment team that's meeting together regularly, co-located together so that they can communicate about what they're doing with the person and their family and with each other. You know, I've come across instances where well-meaning members of treatment teams have done really stupid things, you know? Things like: the person missed their appointment for their Clozapine; they have a history of bad things happening. Right, okay. It's important we get onto that. Okay. I think they're working today. We'll send the police round to their workplace.

You know? I mean this is just horrific. But the person who did that was a really well meaning, thoughtful OT, you know, that thought that was actually the right thing to do.

MS ABRAMSON: So, Mr Waghorn, that is incredibly helpful. So I guess the model you're thinking about you'd have someone probably on salary to do that as part of a team based approach.

MR WAGHORN: Yes.

MS ABRAMSON: Rather than the fee for service that we've got at the moment with employment.

MR WAGHORN: Well you can still do fee for service.

MS ABRAMSON: Yes.

MR WAGHORN: And those fees can be used to pay the salary. So you can have outcome based fee structure. So rather than paying for the services the way the DES system might do it, in terms of large amounts of fees up front and for regular contact with a person, you can just pay outcome fees, and the reason that outcome fees are important is because they force the service to get a better employment specialist if that one is not working. You know, if they're not making any money from the person's salary they're going to have to get the money from another part of their system. So no manager would want to tolerate that, and this is that kind of game. The consumers and the clients will not benefit from ineffective employment specialists, and if that person is ineffective you need to get another one, you know, and that's okay.

Some people are very, very hard to train into this role. For instance, you know, I've had people who came across as very good employment specialists when they were interviewed. When you sit down and talk to them they sound like they would do everything right. But when it came to doing the job they had this kind of allergy with employers, you know, they were kind of allergic to a workplace. So they wouldn't leave their office and they wouldn't go to a workplace. Not only that they wouldn't do any cold calling, and cold calling is one of the most

effective ways of creating job opportunities because that's just the beginning. You know, a good employment specialist will walk into a workplace and look around at what's not being done and say "boy have I got a deal for you", you know, "I've got someone that wants to do that kind of work. You're not doing it, how about we design a job for 10 hours a week and, you know, you pay the person and we'll see what they can do and how well it works out" and it's fabulous.

MS ABRAMSON: One of the things you've talked out really is flexibility, and this is all about flexibility but we have Centrelink and Centrelink assessment. So we're really interested in how could we get people into those type of programs in a more seamless way?

MR WAGHORN: Okay. Well the best way is to bypass Centrelink. Okay? Centrelink has a - is what I call, using my military terminology, a major embuggerance, you know, and that's because they're - their assessment system, you know, they have a thing called a - JSI?

MS ABRAMSON: JSCI - - -

MR WAGHORN: Job seeker classification index?

MS ABRAMSON: - - - and they have their ESA too. I won't go through the acronyms.

MR WAGHORN: And then there's ESA.

MS ABRAMSON: It is complex.

MR WAGHORN: Now the trouble with those assessments is that they prove and putting in effect of a classifying the level of psychiatric disability in relationship to employment. Okay? They can't do that, but Centrelink, you know, are a large bureaucracy and they can't go round admitting their failures like that. They can't go round admitting that their classification systems are pretty much useless for this whole population. So we don't ask them to do that. But what we can do is ask them to simply tick off the works test as being met for every person that volunteers for say an IPS program connected to a mental health program. So if everybody in a valid state government funded mental health program, they're already in need of some major state government services here, they've now signed up to an IPS program, which is a fairly intensive - or should be - vocational program.

There's nothing more that person can be doing to advance their vocational pathways. So how could they not meet any Centrelink requirement by doing that? Centrelink doesn't need to know how many jobs they've applied for. Centrelink doesn't need to know how many hours a week they've - they don't need to know what the IPS consultant has been doing on their behalf. They don't need to know any of that. They just need to know that they're active participant in that program. They're still in touch with their employment specialist and all other requirements could be said to have been met.

MS ABRAMSON: You've said clearly the people who undertake this role have to have a particular skills set.

MR WAGHORN: Yes.

MS ABRAMSON: Do you want to elaborate on what that actually looks like?

MR WAGHORN: Okay, so there's eight principles of the IPS program, and the person has to be able to conduct themselves in a way that fulfils those principles, and the principles are really basic things like being client centred, listening to the preferences of the people you're working with, aiming for competitive employment jobs, placing people in jobs that aren't enclaves, placing people in jobs where other people with disabilities aren't already there saturating the workplace. So normalising the workforce as much as possible by placing people where regular folk who don't have any health conditions might be working. Following the person's preferences. Providing continuous support as long as it's needed by the person, not having arbitrary cut offs. So those principles are also captured and measured by a fidelity scale, which currently has 25 items.

And we would expect a person learning this role to be able to reach good fidelity or better within about three months. So we can score them. We can measure them, and if they need more training and support we can send a more experienced employment specialist with them to teach them - probably the most challenging part of the role is the interface with employers, you know? Having said that there's plenty of employment specialists who don't engage particularly well with participants too, so engaging with participants, helping participants to feel comfortable because this is really important because a lot of participants in this program will have quite strong fears about employment, and these fears won't be the kind of things that they'll mention first up.

They'll wait until, you know, there's a sympathetic ear for that before they mention it. Sometimes the first sign you have that a participant has strong fears about employment is when they don't turn up for an appointment or don't turn up to the workplace or leave the workplace suddenly for no apparent reason. So that's one set of skills related to the engagement with the person, because it's their goals you're using and you're not substituting your views of their career on them, you're using their preferences to guide their life. It's their life after all. But the whole other side of it is the employer engagement because you can't just go to an employer you barely know, in a business you barely know and say "boy have I got the ideal worker for you" because that's a complete fantasy. How would you know?

You know, you really need to take the time to get to know the employer and their business, and for employment specialists working in this field the critical thing here is that it's a relationship building exercise. It's not a transaction. It's not a one off transaction. You're not trying to sell anybody a box of cookies. You know? You're trying to sell a lifelong relationship with that employer in order to help solve their future recruitment needs as well as filling a particular vacancy or spot right now, and that long term relationship view means that you become stable in the job. You look to your network of local employers first. After a little while those employers come back to you with offers, you know, for jobs and that can mean that that person becomes so much more efficient and effective than if they're constantly having to go to employers to search out opportunities.

MS ABRAMSON: Could I also - thank you. Could I also ask you about funding? I know that you've done some previous work on this, but we're very interesting in any up to date figures around the funding because it has great - the things that we've seen, great outcomes but it's

quite an expensive program, all things being equal. So we're interested in some more data if you have that available.

MR WAGHORN: Yes, we've written about this and we've compared the cost of IPS done properly to a DES type service.

MS ABRAMSON: Yes.

MR WAGHORN: And what we found the IPS is actually cheaper if it's done well. It's cheaper because, you know, there's maybe a caseload of 20. If more than half of those people are getting and keeping jobs the outcome payments for that will exceed the kind of outcomes that are achieved in DES where less than half of that are obtaining jobs, even if the caseloads are much higher. So the actual balance of the equation depends on how the activity is rewarded. If too much money is spent on a service fee - on up front servicing fees, not outcome fees, that tends to encourage very high caseloads and very low intensity services, which is very bad, you know, if you want to achieve outcomes, so - and that's - - -

MS ABRAMSON: Well, if you've got - we would welcome that (indistinct).

MR WAGHORN: Yes, so we've written a paper about.

MS ABRAMSON: Yes, thank you.

PROF KING: Can I just follow up on a couple of points. Workforce is obviously an issue. To what degree or how would you then roll out - so smaller trials of IPS, for example there's a headspace trial. Let's assume that comes back positive. Want to roll out more broadly, but workforce is clearly going to be a constraint to a broader rollout. Any thoughts on how that should be staged, how we should build in workforce development at the same time as any rollout of IPS more broadly?

MR WAGHORN: This is an exciting problem to have firstly. But, look, any program is up against it at this point. It doesn't matter what the type of program is at the moment. The moment you take a highly effective smaller program and then try to upscale it or expand it its efficacy is going to decline in direct proportion to the lack of thought given to its management, training and development. So all of those things come into play, and we've also written about that. We have a lovely little diagram to show you that divides the whole space up into the factors that, you know, will drive an effective program when it's up-scaled and versus the factors that will constrain it.

So there's a socioeconomic and political context. So for instance in that if the health policy and the disability employment service policy did not align this type of program could never get off the ground. So that's the kind of thing that's being overcome now, but there are other areas too. There's the characteristics of participating organisations, and this is where we need to grow a workforce of people that are delivering evidence-based practices, and currently the DES system is not producing that workforce, although there are examples within DES of people working to this kind of standard.

So it is possible now to recruit people that have some experience and to recruit people that have matching skillsets from the existing DES kind of workforce. It's possible to do that, but because there's not a large supply of those kind of people we need to start in a staged way. So I would suggest a trial of maybe ten to 20 sites to begin with, and I wouldn't be too prescriptive about where those sites were, because if you prescribe them to be in places that were administratively nice, like it might be nice to have some in the remote parts of the Northern Territory, it may be a year or two before they can recruit somebody to do the job. So it doesn't make a lot of sense.

What we need to go with for that first 20 sites is what the Department of Primary Industries call the earlier adopting principle. So any site that says they're ready, that says they have someone in mind, they can recruit quickly, they can - let's say they can do it, get them going.

PROF KING: So coming back though to that particular workforce training. So a site says, yes, we're ready to go, they may have somebody in mind to fill the role, but how do you make sure the fidelity, if I can call it that, of the person who's going to be providing those employment services, how do you make sure that they are the right persons. Does it need some sort of formalisation or - - -

MR WAGHORN: Yes, it sure does. You can't leave it to each individual site to think that they can solve all the problems around recruitment, training and performance. You need a technical support team that's central that can help sites with selection and recruitment and training, and then go on to measure the fidelity of their activity at that site, and then go on to help them with evaluation and performance monitoring. So that (indistinct) assistance team has almost been established in Australia.

We had the Western Australian Association of Mental Health, IPS works team doing that for a number of sites around Australia, but unfortunately one of their key workers became sick last year and has left it, and I don't think that particular service is capable any more of doing that at a national level, but that's the kind of team we need to establish, a team of about five people probably, maybe in the Federal Department of Health or linked to them; administrative contract, a single contract via a single Federal department; not a site-based contract as the headspace trial used. That was way too complicated.

You need a single contract with central coordination, management, fidelity assessment, technical support, all from one place, reaching out to these sites. Because even if you achieve good to high fidelity at each site and you recruit somebody good and it looks great we know from our research that that does not always translate into high performance. It's around about 37 per cent of sites are likely to be high lows. High low means that they're high on fidelity, so they look great, the practices look great, but the performance is low, and their performance is low because some of these things on this chart haven't been taken into account. Things like removing non evidence-based practices, lack of training, lack of resources, lack of evaluation and feedback for instance.

PROF KING: Are we able to get that chart formally submitted, just because the chart doesn't go off on the transcript, so - - -

MR WAGHORN: Sure. It has been. It's part of the paper that's already been sent to you.

PROF KING: All right.

MR WAGHORN: But I will give you this copy.

PROF KING: That would be fantastic. Just a last one from me. IPS as I understand it where it's been used successfully overseas has been geared towards people with more severe mental illness. Do you see that as being the best approach for Australia? Do you see that as being the starting point for Australia? Do you see IPS as being more relevant for people with more moderate mental illness? Just a bit of a feel from you about where you would see the boundaries of an IPS model.

MR WAGHORN: That's a great question. The thing about IPS is that it was designed, created and designed to help those who are considered to have no prospects whatsoever of employment by anybody ever, and this is typically in mental health units in the US where people would go along for their medication and whatever and they would get supported accommodation; they get a whole range of assistance mainly, you know, depending on what state they're in, but nobody ever thought that they could work, and if they were offered employment it would be in some kind of sheltered facility where they might be invited to go along, and it was only when Bob Drake and his team back in the early 90s started proving otherwise, you know, that employment became a real goal for people with severe mental illness.

Yes, it was always aimed at those with co-occurring severe mental illness and substitute disorders and other forms of complex and severe psychosocial disabilities, it was always geared for them, but in my history working in vocational rehabilitation and working in research what I found is that water only flows downhill, it doesn't flow uphill, and by that I mean is that it's easy to change an intensive service into a less intensive one as the needs of the participants reduces. It's not possible to make a less intensive service more intensive, because the staff don't have the skills or the wherewithal to do it. As a matter of fact they're usually phobic about helping anybody with slightly more than their average degree of difficulty.

So for instance, what is it called now, Job Start, Job Start in Australia, a completely useless service for people with severe mental illness, because they start in that system - - -

MS ABRAMSON: Jobactive.

MR WAGHORN: Jobactive, yes, okay. That's about the sixth name it's had since I've been - so that's a low intensity mainstream unemployment type service, and even though it has four levels of assistance within it, and it might be three now, I'm not sure, but it still doesn't work for people with needs above that, because the staff can't deal with it because they're under too much pressure of volume. They have got such high case loads, such high volume. The moment they have to stop and support any one individual kind of stresses the staff out, stresses the organisation out. All kinds of people have little panic attacks, you know, over it. You just can't do it. Like take a really good employment specialist working in an IPS type program and not only they can provide intensive one on one support and go into a workplace and do the training with that employer and learn to teach the person in that job themselves and do everything like that, they can also then run a job club, they can coach five or six people at once who are capable of looking for their own jobs and they can back off their role or water down

their role to match the needs of the people they're working with, but they can't have it any other way.

MS ABRAMSON: Thank you.

PROF KING: Thank you.

MR WAGHORN: It's all about our settings.

ABRAMSON: No, that's been incredibly helpful, thank you.

PROF WHITEFORD: Thanks for your input.

PROF KING: We will take a break for morning tea and reconvene at 10.50, so 20 minutes.

SHORT ADJOURNMENT

RESUMED

PROF KING: All right, let's recommence and next we have from the Royal Australian and New Zealand College of Psychiatrists. If you could introduce yourselves and formally restate the body - and I should check that the transcript is all ready to go, excellent - and any opening comments you would like to make.

PROF EMERSON: Hi, my name is Brett Emerson, I'm the chair of the Queensland branch of the Royal Australian and New Zealand College of Psychiatrists.

MR REEVES: Troy Reeves, policy adviser of the Royal Australian and New Zealand College of Psychiatrists.

PROF EMERSON: So let's get under way. So we welcome the Productivity Commission's involvement in mental health. There are probably four topics that I would like to sort of have a chat about today. The first one is the fact that existing public sector mental health services are grossly underfunded. So people keep complaining about the fact that the public sector can't provide this, can't provide that. If you look at the national mental health planning framework in Queensland the general adult mental health services are probably funded at about 50 per cent of what's required, and older person services are funded at 30 per cent of what's required. So we really do need to emphasis from the Productivity Commission's point of view the fact that the need for community-based adequately funded services is essential, and they are not adequately funded in any state, particularly Queensland.

The next comment is the Commission talks about in its report the need for activity-based funding for community mental health services. I've got some reservations about how that would work. As I say Harvey and I can debate that, but as I say I'd just like it on record that

we do have some concerns that they may not work in favour of the community mental health services.

The next area to sort of talk about are these regional mental health commissioning bodies that are being spoken about in the report by the Productivity Commission. Whilst it's a good idea there are significant barriers to its implementation, and I will give you an example. So in metro north where I currently work we've got a budget. The mental health budget is about 200 million. The PHN budget is about 18 million. There would then be - there's a lot of private psychiatrists in metro north in the catchment area. If you pooled all those funds it would be very difficult to un-fund certain areas. So I think my own view is that it would be very difficult to say to metro north, well, we're not - whatever the commissioning body is - we're not going to fund \$10m worth of services for a new - we'll give this to a PHN or something type service, and a lot of these places have full-time employees, permanent.

So moving the funding I think will be awkward. I think certainly for new funding having such a body would be very, very good, and as I say currently metro north mental health and the Brisbane North PHN sit as one, and as I say when new funding does come in we do cooperate. For example the manager of the PHN is on the mental health executive for metro north, and vice versa, I sit on their peak mental health committee. So when there are new funds we are able to influence which way they're spent. If you were to go ahead I think it would be ideal to trial it somewhere rather than just having a carte blanche acceptance that that's the way to go.

The final area I would just like to say something about is the role of state-based Mental Health Commissions. There's nothing in the report - there's talking about a national body, but there's nothing about the State Commissions. The Queensland Commission currently is proving to be highly effective. The new Commissioner, Ivan Frkovic, has really revolutionised the way the Commission is functioning. His ability to get to key stakeholders outside of health is increasing, and as I say I think it would be good to continue, particularly in Queensland, having an independent Mental Health Commission to watch over the state-based services. That's it from me.

PROF KING: Okay. Let me start at the last one. So if you've got a National Mental Health Commission that's taking on a broader role of bring the data all together, managing the evaluation process of services, and keeping an eye on the system at a national level, would you see then - the Queensland Mental Health Commission and (indistinct), if you're doing that on a national level you will still need to keep your eyes - - -

PROF EMERSON: I still think you need - well, the state is still going to be a major player and probably a major deliverer of mental health services into the future, and as I say the Commission's role is to make sure not just health, but housing and transport and all the other government agencies, police, ambulance, are involved and that their responsibilities are recognised and carried out and monitored. So I still think there's an important role for state-based commissions. Now, there are some states that don't have commissions, and as you know in WA they've been a funded - Queensland decided not to have it as a funded, so there are different models, but I guess what I'm saying is that the Queensland Mental Health Commission from the college's point of view is functioning well and is highly effective.

PROF KING: I guess seeing where that would fit in, and recognising that we have very different models around Australia, would it be the case that what we want is the National Mental Health Commission and the equivalent of what the Queensland Mental Health Commission is doing either directly overseen or in some way connected in with what the National Mental Health Commission's role would be.

PROF EMERSON: Correct.

PROF KING: Okay.

PROF EMERSON: That's my view anyway.

PROF KING: Yes. One other one from me before I pass to my colleagues. The barriers that you mention - and agree with the issue of trials, but how much of the barrier with existing services relates to transition and the need - carefully transition over time to any new model, and in a sense is that a short term barrier if you came along tomorrow and sort of said, 'Right, we're going to throw services up in the air and' - - -

PROF EMERSON: Yes.

PROF KING: - - - that would be good for consumers but that would be a pretty bad outcome, quite frankly.

PROF EMERSON: Yes.

PROF KING: So you need to transition it. To what degree is it really a transition strategy that you would need no matter where we're going in our funding model?

MR EMERSON: Sure. I think, you know, the practicalities, for example, if you're a private psychiatrist sitting on Wickham Terrace, if there was a body that had control over your funding, is that's what proposed?

PROF KING: No.

PROF EMERSON: No. That's not what's proposed. Good.

PROF KING: No.

PROF EMERSON: Okay. But the idea of, you know, say a large public sector organisation with permanent employees saying, for example, that we're no longer needing that service now. Some people can be redeployed admittedly. But there's not a lot of flexibility in the way people are employed.

PROF KING: Yes.

PROF EMERSON: That would be my reservations.

PROF KING: Given that most of the contracts at the moment – so you've got MBS funded services and then you've got contracts and most of the contracted services tend to be one year contracts at the moment.

PROF EMERSON: Your point is the State based employees are permanent public servants.

PROF KING: That's my point and particularly - - -

PROF WHITEFORD: And fiddling with, you know, their finances, you might lose the support of the HHS's, that's what I'm saying.

PROF EMERSON: Okay.

PROF WHITEFORD: Yes.

PROF EMERSON: Look, I think, you know, the other thing that's sort of happening in Queensland is that there's been a rationalisation in the NGO funding to sort of regional groups. In metro north we used to have about eight or nine NGO's, the contracts have now been consolidated down into one or two with a focus on, you know, referrals from the mental health service and the PHN. So a lot of good has happened with the NGO sector and the way they interact with the public sector now.

PROF KING: How long are your contracts?

PROF EMERSON: I think they're three years with another two year option now.

PROF KING: Okay.

PROF EMERSON: So Richmond Fellowship got the majority of the money for metro north and I believe that contract's three years with a two year option. That's my understanding. So they do have some ability to plan and recruit and, you know, after as you know, in a 12 month contract by about seven months the employers are looking for their next - - -

PROF KING: Next (indistinct).

PROF EMERSON: Yes. And they leave.

PROF KING: It sounds like you're ahead of the rest of Australia in that (indistinct). Did you want to continue?

PROF WHITEFORD: Yes. So understanding that the regional commissioning authority is – the small print says that the MBS money for medical practitioners, (indistinct) psychiatrists, GP's, remains within the MBS. So it's more some of the other MBS money (indistinct) better access - - -

PROF EMERSON: Okay.

PROF WHITEFORD: That might be moved over time. Again, the in-patient unit money has to be run by the hospital but clearly has to be planned and delivered by this proposed regional commissioning authority. So there are some nuances in what sort of – we understand the limitations about how that would work and we don't want to turn mental health into a silo in the community. So it's getting that balance right, that balance between integration and yet being mainstream, that's - - -

PROF KING: And the thought of having a trial first, for you implemented universally.

PROF EMERSON: Sure. We thought Brisbane north would be ideal actually, so yes.

PROF KING: Very willing to talk.

PROF WHITEFORD: My question, I guess, then was about this activity base funding in the community. So one of the things that does concern the Productivity Commission is sufficiency as you'd understand and block funding had some advantages. But also we would like thing about – we're sensitive to the challenge of inpatient activity based funding approach being driven by – over the years. But in the community can you suggest ways in which we could improve sufficiency within, you know, whatever the blocked funding was?

PROF EMERSON: Certainly if you speak to most community health staff in the organisations that I work in, it's the data entry and all the requirements from the information system that eat up probably 20 or 30 per cent of their time so - - -

PROF WHITEFORD: What other people might call red tape.

PROF EMERSON: Red tape, yes, yes. So, you know, if you actually had an information system that was up to date. So currently, you know, where I work say at Royal Brisbane or Prince Charles, a community mental health worker will go out, they will write, 'They saw Harvey at 8.30, they saw Brett at nine o'clock, they saw Trevor at 9.30 but they write that on a piece of paper and when they get back to the office at 4.30, they've got to manually enter who they saw, how long they saw them for, you know, whereas there's technology now that you should be able to swipe that information in. So a decent information system wouldn't go astray.

PROF WHITEFORD: Okay. That accepted, so with a decent information system, how could we collect data that we knew across Australia that we were improving contact with consumers, consumer based activity as opposed to activity that we don't think is productive?

PROF EMERSON: Good question. I'm not sure I've got an answer.

PROF WHITEFORD: When you do, send us an email.

PROF EMERSON: I'll send you an email, yes. At midnight tonight.

PROF WHITEFORD: I think we're done. Thank you very much.

PROF EMERSON: Thank you very much.

PROF KING: Is Christine here? Christine, yes. And if you'd be able to state your name, the capacity in which you're appearing and any comments that you'd like to make.

MS NEWTON: Hi, my name is Chris Newton. I was a registered nurse for 32 years until I sustained a mental health injury. Hopefully I bring a bit of both of my history as a registered nurse and also my lived experience. I apologise for this, this is why I've got a beautiful support person next to me in case it gets away.

Okay. For the first ten years I was treated with nine anti-depressant medications. None were clinically indicated. These caused significant adverse drug reactions, the adverse drug reactions included mood instability and anti-depressant induced suicidal ideations. I stopped all anti-depressants three years ago, I have no more mania, no more suicidal ideations. For the rest of my life I will live with bi-polar, a cascade of medical complications and the social injuries.

I read the Productivity Commissions draft report, 1200 pages with one question in mind, will it protect others from what I went through. Sadly, I found very little that would change my outcome. So this brings us together today.

So with bi-polar, there's 352,000 people in our community with current symptoms. In our life, eight to 14 per cent will die from suicide, that's 28,200 to 49,300 of us. Twenty six per cent will attempt suicide, that's 91,600 of us. There is no data on suicidal ideations, it is our silent killer, the pool where suicide arises.

So the 3000 who died from suicide, 25 per cent had bipolar disorder. That's approximately 750 of per year. For those who survive, the quality of life is at best grim. The statistics don't reflect me. I had mild depression from peri-menopause at 45. This was complicated by my drug reactions. The fallout from this reached every part of my existence. I lost my career, income, identity, friends, family, finances, credibility, and purpose.

I now have two auto-immune diseases, complications from lap ban surgery, I take seven medications a day. I have treatment resistant mental health injury, I'm on the disability support pension, struggle with socialising, have anxiety and around the corner awaits old age, polypharmacy and obesity fallout. It was only perimenopause. The PC needs to add red flags on all data collection and more red flags to reassess and refer for second options, opinions even. The answer was there from week one, treat the cause. I am a failure of the mental health system, the red flags now need to be built in to all data collections systems and early access to experts available long before my illness became an irreversible systemic chaos.

So in the draft report, my treatment concerns are systemic and within the scope of the PC to change. I know there is a place for anti-depressants with monitoring for adverse drug reactions. I am hopeful for the future but experts in bipolar need the tools to care for their clients and to make change. I am concerned a no wrong door integrated single care plan approach is too broad to make this change. One size does not fit all. It assumes care providers are generalist. It leaves opportunity for large gaps and fails to target care to meet consumers' needs. It would not have protected me.

The no wrong door. Finding the right psychiatrist with specialty knowledge in bipolar took me ten years. GP's and consumers can only establish the care provider's scope of practice through self-marketing on websites, word of mouth, trial and error and internet ratings. None of these are reliable. So how can consumers get the correct information or minimise the risk of wrong doors. Who is matching the consumer's need with the right care provider in any speciality? Just because it's all in your head, doesn't make it all the same.

To minimise the risk I'd suggest that all new clinical practice guidelines should become mandatory CPD's. This will assist consultants to remain current in their practice. It's time for the Royal Australian and New Zealand College of Psychiatrists to make bipolar affected disorder a sub-speciality. It's a large population with complex lifetime disability which is easily mismanaged and has poor outcomes. Despite this, bipolar is considered the bread and butter of every psychiatrist. It's like asking an orthopaedic hand surgeon to operate on your spinal injury.

Integrated single care plan, what I lack through my treatment were experts. I propose a specialist clinic that will support single care plan providers so they run parallel with each other. Example, a bipolar clinic would provide a time limited multidisciplinary assessment, case conference with these people from the multidisciplinary team, a second opinion and treatment plans without losing the continuity with the primary treating health workers.

Each mental health illness has its own challenges and solutions. In bipolar, a psychologist would have specialised knowledge in interpersonal and social rhythm therapy. You have heard from people with lived experience who discuss how they have minimised pharmaceutical interventions by managing their circadian rhythm. Did you know that blue blocking glasses can be used for mania? CRP's are now used to track bench marks, faecal transplants may be a future treatment option and when hypo we can convince the best social workers that our spending is justified.

It's only through such clinics that the Productivity Commission can state we now provide experts with current evidence based assessment and treatment plans that is accessible to all consumers when they need it. This will place Australians at the best possible position to receive best practice. I provided details on how this could be operated in my submission, a No.454 that I did earlier in the year.

New science and therapies and technologies are coming. They target treatment, they (indistinct) rapidly available, they need to be affordable and it should not be the consumer's responsibility to seek them out. They should be aware these include genetics, neuroscience, pharmacogenetics, and you were talking earlier about how we can get more of this information in. Smart phones are excellent, they are actually now able to collect information on their apps, about – that the consumer can input and they have also got – they're on the verge of getting facial emotional recognition. This information can be downloaded straight to the care providers.

Microbiome, integrated GP's, they've got a lot to offer, (indistinct) and combination therapies. There is hope but targeted interventions need to be accessible early in treatment before you get to that point where my condition is no longer be able to get pushed back to just perimenopause.

Let's get the elephants out of the closet. Antidepressants induce suicidal deaths. Again, I found nothing in the draft report that would protect consumers from this.

My suicidal thoughts started within months of my first antidepressant. A psychiatrist believed that that meant I needed more. I believed her. A box promised antidepressant (indistinct). For ten years I battled through thoughts of taking my life, benign things became opportunities. Standing on a veranda was no longer about the view but the fall. Lifeline helped me through the worst.

The suicidal thoughts stopped completely when I ceased antidepressants three years ago, I've had no more. The cause and effect became very evident. I'm not alone, I belong to a closed bipolar discussion group with 3,000 members, it's a safe place to discuss suicidal thoughts. What's terrifying is when the same people state, 'I've tried so many antidepressants and nothing helps.'

Occasionally admin gets messages that somebody we know has suicided. In my submission I discuss current evidence based treatment guidelines to protect people living with bipolar effective disorder. Consensus reports stated that there is weak evidence for the use of antidepressants with potential hazardous outcomes in people with a mixed state. Algorithms were provided to mitigate these risks. What I struggled with most is that if this information was provided in the 2004 practice guidelines, 15 years ago and predating my illness. The consultants I had trusted had harmed me and there was no system in place to protect me or others like me.

Four psychiatrists documented in my medical records that I had an adverse drug reaction to serotonin medications. This reaction was toxic to my brain, if it was hepatotoxicity or nephrotoxicity, blood tests would have told them to stop or use less. There is a mentality that it was neurotoxicity then just one more drug could be tried. This is not evidence based.

Mary, in our closed group shared that she is having weekly ECT whilst on two antidepressants. She feels this is her best option for her mixed features. In submission 504, the coroner dismissed the link between antidepressants and her suicide and indicated that she did it with intent. I had endless failed attempts to have my adverse drugs reaction masked or buffered by mood stabilisers and antipsychotics. Nobody considered relieving the cause. I lost everything that gave my life value.

So evidence based research exists, the 2004 guidelines were instigated 15 years ago, consensus reports had been completed, guidelines and recommendation boxes were updated in 2015, algorithms for care are provided, TGA warnings are in place, the retraining phase is finished. There is so much at risk and so much complacency, 352,000 with active bipolar disorder need to know if more can be done to prevent a drug induced injury and improve their outcomes.

We need to assure that not one of the 750 bipolar deaths each year is attributed to antidepressants. You guys need a breather.

PROF KING: Keep going.

MS NEWTON: I - - -

PROF KING: How are you going?

MS NEWTON: I'm find, this is my one chance guys. I'm going to get this out because I'm going to regret it if I don't get this opportunity.

PROF KING: Keep going then, keep going.

MS NEWTON: Okay. So to date, TGA, the Royal Australian New Zealand College of Psychiatrists, AFRA, the coroner, suicide prevention programs have not protected us. The only way to achieve an immediate action required until new preventative reforms are in place is through a government inquiry into the use of antidepressants outside the treatment guidelines, the consumers living with bipolar effective disorder. My credibility has changed with my diagnosis. Stigma is very real. I request the Productivity Commission to make a recommendation to our government for the government inquiry to protect their consumers.

So, next topic. Root cause analysis is another step that we can take with suicide prevention. It is needed to establish if there is a relationship between bipolar consumers who are prescribed antidepressants and those who attempt suicide, or have completed suicides. To do this, consumers with bipolar affective disorder on antidepressants must have suicide attempts reported as near misses, and deaths from suicide to be reported as a sentinel event.

The Productivity Commission mentioned that there's 30 trials underway on suicide prevention. Are any looking at the incidence or outcome of people with bipolar disorder, or is the 25 per cent of bipolar hidden amongst other demographics? Is their gaming?

Health rights. My right to self-care - safe care was withheld. My right to make an informed consent was withheld. I placed a complaint with AHPRA. I was advised that as there was no quantitative evidence in mental health, and no witnesses, the doctor's version of events was correct. People with mental health who place a complaint should be provided an advocate so that the complaint might get a little bit more of a, you know, credibility.

So, thanks guys for listening. For the record, there is some amazing psychiatrists out there. This isn't an anti-psychiatrist talk. My current psychiatrist tells me he manages all his bipolar patients without antidepressant medications. So there is hope in the future. Thank you.

PROF KING: Thank you.

MS ABRAMSON: You've been very brave and courageous. Thank you for doing that.

MS NEWTON: I've got bipolar. You can't shut me up on a good day.

PROF KING: Harvey, would you like to?

PROF WHITEFORD: Thanks, Christine. So there's a lot in what you've said, and so we can't probably go through them all. But there's a few things that I'd like to just to get your further opinion on. Part of it, I suppose, is for us about - as a Productivity Commission, not as a clinical research team - to look at the structures, look at the systems. So one of the things

that you've mentioned is off-label use, I guess we would call it, of medications.

MS NEWTON: Yes.

PROF WHITEFORD: So just so I'm clear, what you're suggesting there is that where off-label medications are used, so they're not used for the condition for which they have a prescribing authority, there should be a much greater look at that, and what it's used for, and some oversight of that process. Is that what you were suggesting?

MS NEWTON: Yes, and I think where I find it was that there's still an old mentality in the system that if you have an antidepressant, it must have a mood stabiliser at least, minimum, there to stop any adverse drug reactions. But I think where the system misses is that you've got the antidepressant, it's going to give you some antidepressant properties. There's a risk of instability in certain classes; people with bipolar. So by putting a mood stabiliser on it, this rattling around here might be calmed down a little bit.

But in a lot of people, all it's doing is - like, I was in this picture and I had my mood stabilisers and antipsychotics put on top of it, but sitting in here was failure to get to remission. It was losing my career. It was losing my life. It was losing everything. I would have episodes of mania. I'd have intense depression. I'd have a lot of mixed state and rapid cycling happening, but in 10 years I never achieved remission. So this thing that if we just put this stuff on top of it, is not the answer.

PROF WHITEFORD: No, I understand.

MS NEWTON: That needs to be re-educated.

PROF WHITEFORD: Okay.

MS NEWTON: It's not until the cause is removed that I managed to stop the suicidal stuff and stop the mania.

PROF WHITEFORD: And the cause was?

MS NEWTON: An adverse drug reaction.

PROF WHITEFORD: Okay.

MS NEWTON: Yes.

PROF WHITEFORD: Jumping to the issue about the bipolar clinics, and I suppose, without wanting to make that sound like I'm not listening to what you said, we could have someone with an eating disorder here, or we could have someone with a - you know, whatever, and saying we need a specialist clinic for all of the areas.

MS NEWTON: Totally.

PROF WHITEFORD: How do we deal with the fact that that's great for the people who get

into that specialist clinic, but we can't have specialist clinics all through Australia for every type of disorder.

MS NEWTON: Okay. In one way, it's time limited. It's a one-off assessment. So, you know, depending on where the resources are, it's only one or two days to come in, get assessed by experts who know what's happening on the cutting edge, who understand the disorder, who don't leave me for 10 years like I was, and who are multidisciplinary, who case-conference you, write a plan, and send you back to your care providers.

PROF WHITEFORD: I see. Okay.

MS NEWTON: Similar to what Black Dog's doing, but multidisciplinary. And, you know, if that's in Brisbane, then I'd happily come from, you know, Cairns down, to do that, to get me out of the mess I'm in. I would have done anything.

PROF WHITEFORD: But then the treatment could be delivered up in Cairns.

MS NEWTON: Sorry?

PROF WHITEFORD: But then the treatment, once it's planned, probably - - -

MS NEWTON: Absolutely.

PROF WHITEFORD: - - - could be delivered in Cairns.

MS NEWTON: Yes. So it's not taking away your system. It's adding to it, and if that needs - and I totally agree. You know, I've totally got total needs than somebody who's got an eating disorder, postpartum issues, what have you. So yes, put it there. But there's some great experts out there who walk and talk bipolar, and that's not just in psychiatrists, it's also in psychologists and, you know, social workers and all the rest.

We did a system very similar when I worked in transition care in - for aged care. It was a three month, because the people needed this period. But everybody who provided them their multidisciplinary care specialised in aged care rehabilitation. So they weren't the - they weren't a physio from the hospital. They weren't the physio in the community. They specialised in this rehab, and so they got nothing but the best, and at the end, it was handed over to continue on these plans in the community. So it's the way to make sure.

PROF WHITEFORD: So are you saying that, rather than trial and error with someone who perhaps hasn't got that level of expertise, get the experts in, the best people involved right at the start, and then they're more likely to - - -

MS NEWTON: When they need it. There's some people that don't need it from the start.

PROF WHITEFORD: Okay.

MS NEWTON: But, you know, a year down the line, I was just screaming that nothing's working, and I had no capacity and all my people around me didn't know where to send me,

and my psychiatrist (indistinct) every silo in the private system.

PROF WHITEFORD: One more question.

PROF KING: Sorry, because I want to follow up on that.

MS NEWTON: Yes.

PROF KING: So, in your situation, did you experience misdiagnosis, or was the diagnosis correct from the beginning, but the treatment wasn't appropriate?

MS NEWTON: I was misdiagnosed. I had an 18 month period before bipolar symptoms were actually diagnosed. In that 18 month period, as a consumer, I can tell you that I had symptoms that indicated it was a bipolar depression and not a unipolar depression. So a good treating psychiatrist should have been able to pick that up, and then - so, the other things that were missed in my diagnosis was that we were treating my perimenopause. You know, that was six years down the line before I had treatment of that, and that changed where I was.

And there were other little things that crept up the line as well that were missed. So I think you are brought in, you talk about the drugs you're today. Because you're not stabilised, people want to drill into your mother, where really I had mum in a box for the last 45 years. I didn't need to bring her out of that box. And, you know, they kept trying to find other problems, but nobody removed the cause, and drug induced bipolar disorder is a real cause. So I was sustained in that state.

There's this thing that you get a mood switch. Nobody sees the mood switch when you stay in that spot forever, and I think that's where you need experts to say, forget looking for the mood switch, this is not treatment resistance. This is drug induced, and we're brave enough to take the drugs off her, even though she looks really depressed in her mixed state. And I think that's - you know, when you're sitting there and you're going, I'm suicidal, and I look depressed in mixed state, they're going, oh, I don't want to take those antidepressants off her, and they don't. But they sustained an injury instead.

PROF KING: Okay. Sorry, Harvey.

PROF WHITEFORD: No, no. So I was going to ask, how did you find the right psychiatrist at the end? Was it trial and error, or was there some system that helped in that?

MS NEWTON: A book. And I think I had the capacity to read and understand books that other people, the general public don't. I'd hate to have been 18 years old with no - without my knowledge and finding the way out of this.

PROF WHITEFORD: Sorry, when you say a book, you read the name in the book?

MS NEWTON: No, no, no. There was this guy that wrote a book called 'Calm Seas' over in America. Said he could cure things that nobody else could. I got the book through Amazon, and he suddenly made sense of things for me. So I went to my psychiatrist and said, hey, what about this? Another mood stabiliser, and he told me there's no - that's outside his guidelines.

So I went back and said, well, I've got this neuropathy. Let's just throw gabapentin at it and say that's in the guidelines. So we did. I improved daily, and then I took myself off the antidepressants.

PROF WHITEFORD: Right.

MS NEWTON: It was a patient. But look (indistinct).

PROF WHITEFORD: So, but what you're saying is, you worked on it with your psychiatrist. You read up, you were informed, and you and your psychiatrist together worked it out, rather than only relying on one way flow of information.

MS NEWTON: There was reluctance on his behalf. In his time with - I mean, he tried me on four antidepressants. One took me to the point of suicide planning, and in his - now that I've got hold of my medical records, he clearly documents in there multiple adverse drug reactions. There's serotonin allergic drugs. We've got the option of trying her on another antidepressant or retrying her on one she's been on before.

MS ABRAMSON: Ms Newton, I want to ask you about - we've had a conversation here today about psychosocial supports. So the type of support in the community that was important to you when you were unwell, or when you were well, what type of support helped you?

MS NEWTON: I was referred to a psychologist, and retrospectively, my simple answer is, you can't talk somebody out of a drug reaction. And so I had no chance. You know, I had 10 years. I would have seen 150 appointments with psychiatrists. I would have had the same amount with the psychologists, and as I mentioned before, they opened doors when I was unstable that didn't need to be opened. I needed some estrogen, for Pete's sake. You know. And if anything, they made me more unstable.

I went to the International Society of Bipolar Disorders conference this year. I sat in and listened to the talk on circadian rhythms and social rhythms and what have you. I'm using that. I'm still self-educating.

MS ABRAMSON: Do you think that - you mentioned before your complaint to the AHPRA.

MS NEWTON: Yes.

MS ABRAMSON: And you mentioned patient advocacy, and we've got some recommendations certainly around the Mental Health tribunal. So was your view that your complaint would have been assisted if you'd had access to professional advocacy, or lay advocacy, a peer support worker?

MS NEWTON: I think it's got to be professional advocacy.

MS ABRAMSON: Yes.

MS NEWTON: Because, you know, when I came here, talking initially, I can be strong, especially on a computer. So I got all the facts. I was very well presented in it, but the answer

was, I think, determined before I even had my complaint taken on, and that was, you know, the psychiatrists are right because it's only your word against his, and we don't have a blood test, we don't have an X-ray in, obviously, your left leg. You know, and therefore, this will be the outcome.

Then the next stage of it was to try and access my medical records through them, through FOI, and I had the same hurdles. The fact that you've got a mental health illness, therefore this information may want you to self-harm. Sorry. And that took me another - the best part of a year to get that. I've gone through OAIC to try and access medical records from a GP. The same thing. That's taken me 18 months and I've only just received those medical records. Because, you know, if somebody did cut off my left leg instead of my right, and I was pretty pissed off at the guys who did that, then I was more at a high risk than what I am.

It is touching discrimination, because why should I have to do this, when the average person isn't, and plus, it's being used by the - not picking on doctors, but they were the people I was getting them - it was used by them to protect their interest, rather than to protect mine. They didn't want me to access it. All they had to say was, we're not sure if she's safe. They didn't have to provide any proof, and that was it. My door was closed.

MS ABRAMSON: No, look that's very helpful, because we have been thinking quite a lot about data and your right to your records and things. So that's very helpful. Thank you.

MS NEWTON: No worries. Yes.

PROF KING: Okay. Were the medical records that you received actually useful when you got them?

MS NEWTON: Yes, they proved what I believed. I think it surprised me that four psychiatrists had actually all documented in my medical records that they were aware that I had adverse drug reactions. Not one of them had advised me, though I didn't have informed consent. They were saying, here, have another one, and I was just believing that antidepressants would stop my depression. But nobody discussed adverse drug reactions to me at any point in time, so my right to informed consent was not there.

PROF KING: So, one of the things that the Productivity Commission's worked on elsewhere, and we haven't mentioned in our draft report in any detail, but we're certainly going to look, when we move towards the final, is actually providing the consumer data right, because that's what it's called elsewhere. But making it much clearer that the consumers have that right to their medical information records. Would that have been helpful in your case?

MS NEWTON: It would have. I don't know whether I - yes, what if I'd received it early? It's silly. I've got a mentality of trust that, you know, that I trust they're doing the right thing and that, and you know. But what I've retrospectively was the content was frequently what I - not what I said, and they were interpreting things slightly differently. But I think it remains, you know, you can sit there and nit pick through it all. The biggest issue was the fact that four consultants gave me nine antidepressants and all knew that they were causing harm.

PROF KING: That there was an issue. Sorry. When you were going through the history of

your treatment, you didn't mention GP, I don't think

MS NEWTON: They were there.

PROF KING: Okay. That's all right.

MS NEWTON: But of interest, because I - again, I'm just pulling out the issues to deal with. They're all great ones in there. I think one of the things you do, initially you just trust, because you've never been in this situation before, and it wasn't my speciality knowledge, and then I started, down the line, saying it's not working, it's not working, it's not working, and to my GP and to anybody that would listen, and I had feedback from - initially from one GP, and he neatly documented it in the notes, is that, just go back and talk to the psychiatrist.

I was asking for to be referred to a second opinion, and he suggested that I should go back and talk to the initial one about it, as if, you know, I didn't have that right also to a second opinion. So that was postponed at that time. And, you know, any time I went in there and said I needed a different service, I think when it comes to suicidal ideations, I didn't talk much about it. I was afraid I was going to get admitted. I worked in an emergency department; the last thing I wanted to do was turn up in my own emergency department.

I talked to my husband about it once. The fear on his face, and his anxiety over the next week, I just swore I'd never talk to him again about it because I didn't want to put him through that stress. And then I had the - and my GPs, I didn't talk about because it all fitted into that same thing of I was avoiding hospitals. I lost that thought. So the only thing I had was Lifeline. They were great. They were great. Yes.

PROF KING: Do you know if your GP, psychologist, psychiatrist - you've seen different ones - but did they actually - did they talk together? Did they actually interact as a team?

MS NEWTON: There was one point that the psychiatrist, or the GP contacted my psychiatrist, in that order, and that was after my husband died, so I was in a crisis at that point, and - but otherwise, there was nothing. There was the annual letters.

PROF KING: Okay. Final one, peer support worker and assistance.

MS NEWTON: I didn't know these things existed.

PROF KING: Yes.

MS NEWTON: Because I went into the private system, and I was just seen as an outpatient, I had no knowledge whatsoever that anything existed outside a GP, psychiatrist or psychologist, and I was never referred to any. Would I benefit from one? Yes, I would have. I so wanted to talk to somebody who got it, and that was one of the things I wanted very early in the piece. I've got that now with my discussion group, and it's safe to talk about anything on there. You know, people get on there and talk about what it's doing to their sex life, what it's - - -

MS ABRAMSON: That's an online service?

MS NEWTON: Facebook, yes, and it's not service but it's safe.

PROF KING: Yes.

MS NEWTON: And we know each other. We protect each other. We flag when there's concerns. Admin will actually go and search out next of kin, relatives, whoever, a friend on Facebook and say "this is a crisis position, go and get help", and, you know, it's - it does give wrong information as a registered nurse I sit there and go, "Yeah (indistinct) guys".

PROF KING: Yes.

MS NEWTON: But it's - but I think there's enough people on there to keep the balance there. It's also the word by mouth that is protecting people from antidepressants now. There's a lot of people that get on there and go, "Me too. Me too. This is what I've done" and what have you.

PROF KING: Yes.

MS NEWTON: There's a school of people here that go, "They saved my life. They worked for me."

PROF KING: Yes.

MS NEWTON: But the ones that it's not working for then there's this other little family going, "Question your doctor about this. Change your psychiatrist" and things like that. So this is where our education in the modern world is coming from.

PROF KING: Yes. Okay?

MS ABRAMSON: Thank you. Thanks a lot.

PROF KING: Thank you so much. Thank you for having the courage to come.

PROF WHITEFORD: Thank you (indistinct words).

MS NEWTON: That's okay. No worries. Looking forward to the (indistinct).

PROF KING: Yes, sorry, so next Tania Murdock. Good morning.

MS MURDOCK: Good morning.

PROF KING: If you could state your name. Any organisation you're representing and any opening comments that you'd like to make.

MS MURDOCK: Good morning and thank you so much for allowing me to be here today. I feel that this is an extremely important area for our country and individuals, workplaces as a whole. My name is Tania Murdock. I am a behavioural scientist and I work mostly in the area

of workplace psychological health and wellbeing, preventive measures, working with dispute resolution practices, education, early intervention and preventative measures. So that's the most specific focus of my work and I have been working in this - in the business industry for 23 years. In the last few years I've been working very concentrated with the Queensland Law Society. I am on the wellbeing working group committee, and we do a lot of mental health initiative.

In fact we did a recent workplace cultural change initiative which we're working on building lawyers, particularly within the law industry, because you probably would be well aware the statistics are one in three that suffer from anxiety, depression and other mental illness, as compared to Australia as a whole one in five. So within the legal industry it's quite serious and obviously other industries particularly have higher rates than the general Australian population as well. So I guess if I could give you a bit of an overview with regard to why I would like to make a submission, aside from the fact that I think this is the most important thing that affects everything that happens to us and I'd go - I'd like to go a little bit into the neuroscience of that.

So my background is psychology. I studied psychology and I also became an accredited mediator. So I'm a workplace mediator. I deal a lot with people in disputes and working through their disputes and I find a very similar thing occurring over and over again, whether it's workplace disputes, industry disputes generally or family. I'm also an accredited family dispute resolution practitioner. But similarly the same sorts of things we come across is people struggling with mental health issues. People that also have personality disorders that are not recognised and the lack of awareness generally in society of how to deal with situations where there is high conflict.

And rather than punitive measures by way of punishment et cetera we use methods that would be more of a compassionate sort of approach, and preventative rather than waiting until the problem occurs then trying to actually spend a lot of money, time, stress, and obviously to the detriment of people's mental health at the end of conflict where they may have had years of dealing through a legal system and not really getting anywhere other than wasting a lot of their money and time. So I'd like to just cover a few things. Obviously there's a lot of awareness already with regard to what impact mental health has on our society as a whole, productivity, performance et cetera.

So I'm sure you don't need me to go through statistics on that, however whenever I do conferences, workplace and mental health conference presentations, workshops, and any training that I do I always cover that so that people are well aware of what impact this is actually having because it's surprising the lack of awareness that people actually have. So that's one of the key things that I am very, very happy that you are addressing and that is increasing the awareness into mental health issues and how it impacts across our whole community. So I work along the lines of what can we do to improve psychology safety within the workplace and what can we do to create mentally healthy workplace cultures.

So we obviously are faced with a lot of cultural issues relating to bullying, harassment, discrimination, all these things that have significant impact on people's mental health, and I can see from start to finish sometimes within a mediation - sometimes it might take four hours for the mediation and I can see from the start when I first independently interview the different parties that are involved in a dispute I can see where things have become to really unravel for

them, and it's really unfortunate because I get them at the end in regards to a mediation, I get them when the dispute has been going on for so long and unfortunately had caused already a lot of harm when I know for a fact that if we'd put in preventative measures early, an early intervention and identify the signs before it gets out control I know for a fact that we could actually reduce so much stress.

PROF WHITEFORD: Sorry, can we just stop you there for second, Tania.

MS MURDOCK: (Indistinct).

PROF WHITEFORD: So what would we do? So what would the recommendation be to get in earlier rather than leaving it too late? From your view.

MS MURDOCK: Okay. So education. Identifying the signs. Educating - so if we talk specifically within the workplace, however I don't only work in the workplace - - -

PROF WHITEFORD: (Indistinct words).

MS MURDOCK: - - - obviously relationships generally healthy, psychological relationships. So early intervention would include things such as say for example in the workplace there would be implementation of training and education. Increasing awareness. Obviously the leadership is very important. The culture of the organisation is very important, and so we would need to actually interact with these people and I'm not just saying tick boxes, although I think that there is a method like - that we could actually have a psychological safe workplace and we could actually have a quality assurance process as we do for lots of other things. Procedures. Policies. It's not just a box ticking, but we actually have an ongoing assessment process.

So we need to identify signs. So for example if someone's working in a workplace and they're too scared to approach their boss about an incident that occurs, so the incident just keeps reoccurring and reoccurring and it causes mental health not only to that individual issue but we also see the ripple effect and it obviously affects the whole environment that they're working in. They also take it home, then that affects children's - I do a lot of work with children as well in early intervention when it comes to dealing with parents that are under so much stress and they unfortunately aren't even really aware of how that impacts their children in the way that their behaviours - that they create for their children, and then obviously it's transgenerational effect then.

So they grow up already angry and already suffering things like anxiety, depression. They're too scared to raise issues. If you associate raising a concern with something with punishment, of course you're going to be shy of raising that again. So often I see this coming up over and over again and I really would love to have more support from the government myself because I work in the private sector in this area and I just feel that no one is listening and it's really frustrating and there's so many things - - -

PROF WHITEFORD: Are there some employers which are better than others? Like, is it getting better?

MS MURDOCK: Yes. So, it's interesting because large organisations obviously sometimes have their own mental health, kind of, you know, strategists within the HR Department or something. Sometimes, they're still not fully aware of all these things that I'm discussing today. But the small organisations obviously can't afford to have a full time person just working in that. However, they should really be implementing something on a regular basis where you do have a specialist that is actually working within the organisation to identify signs, because otherwise if people are suffering, they're too scared to say anything, it just – it just keep growing and compounding.

PROF WHITEFORD: Can I come back to that because the key issue, I understand that you can – thing like quality assurance and psychologically safe workplace, but an individual who, let's say they're being bullied, they're worried about raising it, you know, maybe being bullied by their immediate boss, worried about going over their immediate bosses head, the consequences of that, not raising it. You said if there was a specialist who came in and looked for signs, but is that the best way to do it or do we – how do we make sure that link occurs. So you've got the person here who's been bullied, you've got help over here but you've got to make that link somehow and this – the person who is being bullied is worried, afraid, under existing pathways. So what are the pathways that we could put in place in workplaces so that they would become psychologically safe?

MS MURDOCK: Well, firstly some of the bullies are not aware that their behaviour is bullying.

PROF WHITEFORD: Yes, understand. Yes.

MS MURDOCK: So people with personality disorders, particularly narcissistic or border personality disorders, these kind of people that actually present problems for others around them, they don't have insight, that's part of their problem.

PROF WHITEFORD: Yes.

MS MURDOCK: So there's ways and means of educating a whole organisation about trying to work and manage these kinds of people. So, firstly identify the kinds of signs of the individual causing the problem first.

PROF WHITEFORD: Okay.

MS MURDOCK: And obviously if they are a boss which quite often they are, usually they're in a position of power and they do exercise obviously – take advantage of that. So in that case, we need to actually make the organisations, sort of, highlight the ones that are actually participating in these quality care standards of mentally healthy psychological, safe workplace. So, it's like a quality assurance for people to go work for you, just like anything else is, workplace health and safety et cetera that these organisations are actually safe places to work from a psychological perspective, not just a physical perspective.

PROF WHITEFORD: So would you see the others being mandated standards that every workplace would need to meet or workplaces of other certain size or would you see it as being a voluntary approach - - -

MS MURDOCK: I would - - -

PROF WHITEFORD: - - - workplaces could adopt, how do you see it?

MS MURDOCK: I would certainly suggest that you come from both because you can't force people to do certain things. Obviously, if someone is going to be a bully you can't kind of force them not to be a bully necessarily. However, if they don't have any insight into what's going on or even the impact, perhaps there's training methods – well there is training methods to show them or to help them understand what's going on for them and actually make them see it from their perspective.

So, a classic example that we use actually with parents with children, so when they say, 'They grew up in a really happy, healthy family, no problems, no psychological problems, however, they're really angry people. They don't understand where this anger is coming from and they might be bullies themselves. When we drill down to find out what's really going on, you identify, okay, 'You say you had a really happy childhood and, you know, you don't understand where this anger and lashing out is coming from.'

But then when you identify it, when you actually say to them, 'Okay, what sort of things really make you – trigger you into anger, these anger episodes et cetera?' What you'll find is, whatever that trigger is comes from something a long way back. It's not necessarily what's happening right now. We might just be getting triggered right now, but the actual underlying cause comes from a long way earlier on in their life. So what happens then is we try to get them to imagine their own child experiencing the same sorts of feelings.

So, for example, if you saw a child that was six years old that was being bullied at school and they didn't talk to their parents about it. So they come home, they just suffer in silence, they don't mention anything. Then if you tried to imagine your own child doing that and you think to yourself, 'Who did they talk to?' And they didn't come to you, why did they not come to you? You would have to ask yourself, would that mean there was a trust issue? Why would these people not come to you? So in a child's experience why didn't they come to the parent when they were being bullied or any other adverse childhood experience? Why didn't they come to the parents? They were too scared, did they trust, were they fearful?

It's almost identical in the workplace. Same sort of thing, why don't we go to our bosses with these things? Are we fearful, what are the ramifications et cetera? And clearly there are ramifications in organisations where they're not mentally healthy, they're not psychologically safe. But that's the thing we have to change, so we need to actually recommend but also train people in understanding what it is to be a psychologically safe workplace. But also, so that we actually put them up and reward them for that behaviour. Not actually, you know, not just sort of go along with, yes tick the boxes. We need to reward these people for doing the right thing and increasing awareness, increasing education. But not just on one occasion, it has to be reoccurring. Anything that just happens on one occasion is not sustainable.

MS ABRAMSON: Ms Murdock, can I ask you, we hear a lot about what is an unhealthy workplace, mentally unhealthy workplace. What are the characteristics of a mentally healthy workplace?

MS MURDOCK: Mentally healthy, sure. Okay, so if it's okay I could just point out a few things that I was going to raise anyway?

PROF WHITEFORD: Yes.

MS MURDOCK: And some of this hopefully might cover this. So obviously we're enhancing psychological wellbeing workplace, engagement and culture. So we're looking at people, productivity, performance and what effects that. And the evidence shows us that if we – if our teams, our individuals – if we want them to do well then we need those individuals and organisations to be well psychologically.

So we all know that that is very important, we know that that's billions of dollars of waste every year that we're losing, in engagement productivity, absenteeism, presentism - it's interesting that presentism is such a higher rate even than absenteeism. Increased turnover, compensation claims, et cetera. I do a lot of workshops on this sort of thing within different industries.

So, the hidden costs that are associated with mental health, personality disorders, training, prevention strategies, that kind of thing. And the domino effect, how one person, you know, can be affected but then how everyone else around them - - -

MS ABRAMSON: If I could just interrupt you because times a bit pressing?

MS MURDOCK: Sure.

MS ABRAMSON: The Commission is very seized of that.

MS MURDOCK: Yes.

MS ABRAMSON: We understand that but one of the things we were trying to look for is, well what is about a mentally healthy workplace, what is different about it from a workplace we know is unhealthy, and there's a lot of evidence about what is an unhealthy workplace. So what are the positive characteristics?

MS MURDOCK: Sure, okay. So, I have a slide specifically on that but I don't want to take your time to get to that. But basically if I could just, off the top of my head, in a mentally healthy workplace, you would have respectful relationships, you wouldn't have ongoing bullying. You may have from time to time some bullying circumstances but it gets addressed immediately. So it's not something that lingers. You have minimal discrimination, so you have less micro inequity. So you've heard about micro inequities, how they're very subtle, even covert, so you don't really realise they're happening. Just slight things that maybe someone is being isolated from the group or, you know very - - -

MS ABRAMSON: And that's part of the organisational type conversation?

MS MURDOCK: Yes, yes.

MS ABRAMSON: Yes.

MS MURDOCK: And the word, 'justice', is so important. I was reading through the outcomes that you have provided and the justice is such an important area because when people feel like they haven't had justice, that's when they do, you know, the bad behaviour, that's when they really act out. Some of the affects that occur from their sense of injustice, and sometimes it's a perceived injustice.

So often I find, particularly in mediation, whether it's family or workplace, so often I find it's early communication, there's no clarity within their role or within their working relationship, who does what, when do they do it, how do they do it. All that, sort of, like real clear, sort of, organisational procedures, policies, which is really basic, you know, its basic things that can be so much preventing these problems.

I find that – I'm a franchising mediator as well, I find it with franchisors and franchisees and same sort of things. Some of their business relationship planning, it's just got huge holes, big gaps, 'Okay, so what do you guys talk about is going to happen in this (indistinct) when this happens, or when that happens?' No one has a clue. I was in the practice management course doing a psychological health workshop for the Queensland Law Society only in the last two weeks. I asked them, 'Who knows - who has policies within their workplaces on psychological health and wellbeing?' Less than 40 per cent had - - -

MS ABRAMSON: They would have said to you we have anti-discrimination policies, we have anti-bullying policies, but the other side of what you're talking about, they see it in - I don't want to put words in people's mouths - but employers see it as, well these are the things I actually have to have as an employer, but you're talking about how people behave.

MS MURDOCK: And then on top of that - like you might have a policy and tick the box and say, yes, I have got a policy, but then how is that being implemented and how regularly is that being implemented and then what are the consequences if - you know what I mean, if things aren't being followed up and - - -

MS ABRAMSON: No, I do, and I am just a bit mindful of time. We would welcome a written submission from you if you're able to do that, specifically talking about some of those positive strategies and - - -

MS MURDOCK: Absolutely.

MS ABRAMSON: - - - and a healthy workplace, how do you get there.

MS MURDOCK: I'm all for positive preventative strategy rather than trying to deal with the dispute at the end of the day.

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

MS MURDOCK: Thank you. I appreciate your time.

PROF KING: Thanks, Ms Murdock, very much. Next Jamie Shepherd, and if you could state names, the organisation that you represent and any opening comments that you would like to make.

MR SHEPHERD: Thank you. I'm Jamie Shepherd, professional officer - team leader with the Queensland Nurses and Midwives Union.

MS COX: I'm Anne Katrina Cox, I'm a medical nurse consultant. I'm here with the QNMU.

PROF KING: Thank you.

MR SHEPHERD: Good afternoon, Commissioners. The Queensland Nurses and Midwives Union thanks the Commission for giving us the opportunity to present our views on mental health. As I said my name's Jamie Shepherd and here with me today is our mental health nurse member Anne Katrina Cox. We are here to represent the interests of our members. That's 61,000 nurses and midwives who provide health services across Queensland. The QNMU made a submission to the inquiry. We will also make a submission in response to the draft report. We recognise the significant effort the Commission has made in compiling such an extensive report.

Today we will limit our opening statement to the mental health workforce, in particular nurses and midwives. Our submission in response to your draft report will address many areas in much more detail. The QNMU believes nurses and midwives are integral to the mental health workforce in the Australian healthcare system, and believe the mental health workforce strategy must be developed. As part of this mental health workforce plan the nursing and midwifery workforce must be empowered to work autonomously and to their full scope of practice, and this workforce includes services that are led by mental health nurses, nurse navigators, nurse practitioners, school nurses and midwives.

In the draft report the Commission recommends increasing the number of specialist mental health nurses. We support this recommendation, however we suggest there are other avenues to achieve this rather than the three year direct entry undergraduate degree in mental health nursing that was suggested by the Commission.

The QNMU believes the undergraduate nursing or midwifery degrees should be bolstered with more mental health content. Mental health should not be a separate curriculum, but be included in the nursing and midwifery undergraduate degrees to build a flexible, holistic and integrated mental health workforce with a capacity to address mental health concerns across all health services.

Physical health can affect the ongoing mental health and wellbeing of people with mental illness, and mental illness can affect physical health in turn. Thus the QNMU believes the study of mental health should be given equal billing to that of physical health. An option for growing the number of qualified mental health nurses and increasing mental health knowledge and skill could be if an undergraduate degree was offered that included extensive mental health training over a three and a half or four year degree. This degree which would be a dual degree would provide nurses or midwives with generalised knowledge as well as specialist knowledge in mental health.

We also believe to encourage nurses to gain qualifications to practice as mental health nurses requires planning and resources. Strategies to encourage this include providing funding or financial support to nurses to undertake additional study in mental health nursing, like the graduate diploma in mental health nursing scholarship program that's offered by the Victorian - the Department of Health in Victoria; greater understanding of the (indistinct) that attract nurses to work in mental health; providing high quality mental health clinical placements as part of the bachelor of nursing and the bachelor of midwifery undergraduate degrees; providing more attractive employment incentives for (indistinct) a career in mental health, and establishing a chief mental health nurse in every state and territory.

The QNMU would also support the introduction of a specialist registration system for nurses with specific qualifications in mental health nursing. This could be achieved when nurses apply for registration or renew their registration by asking them if they have a mental health nursing qualification.

We also support a review of mental health services provided at emergency departments in both public and private hospitals. Data from various jurisdictions show a significant increase in mental health presentations to emergency departments. That data also indicates that mental health presentations wait a longer than average time for assessment. So we recommend that emergency departments be bolstered with additional mental health qualified nurses to triage presentations in a timely manner and avoid the risk of walk-outs and adverse outcomes for those people.

We would also like to take the opportunity to advocate for ratios. For many years the QNMU has been lobbying to improve quality and safety in health and aged care by introducing nurse to patient or nurse to resident ratios. The QNMU and the Queensland Government are leading the way on this issue where legislation was recently proclaimed that will add Queensland's acute adult mental health inpatient units to the already mandated minimum nurse to patient ratios in medical and surgical units. We believe ratios will lead to better care for those patients and residents with mental health conditions, and we ask the Commission to recommend ratios be implemented in State Government and private healthcare and aged care facilities.

Finally we agree that more work needs to be done on the issue of psychological health and safety in WHS legislation in order to appropriately lift the profile of hazards to workers psychological safety and wellbeing. This should include workplace health and safety regulators and inspectors being well trained and skilled in assessing psychosocial hazards in the workplace and detecting non-compliance and empowering them to enforce remedies. Thank you for the opportunity to present today and that concludes our opening remarks.

PROF KING: Thank you very much. Let me start off and then I will pass over to my colleagues. I want to explore a bit more about thinking about the undergraduate degree and including more mental health units, components in the standard undergraduate nursing and midwifery degrees. I know what the immediate response is going to be from the relevant faculties. They're going to say - and lecturers - they're going to say curriculum is already too full, we have already got stuff that we can't fit in. When they come back and tell us that what are we going to respond?

MR SHEPHERD: What's important. Is mental health important or is it not?

PROF KING: What goes then from the current curriculum?

MR SHEPHERD: Good question. At present we know that some of the undergraduate degrees only offer about two weeks placement in mental health clinical setting, and undergrads get the opportunity to decline to take that placement. Obviously there's going to have to be negotiation on what can be dropped off and what can be added to improve the mental health curriculum inside that undergraduate degree. Is there stuff that's being taught in the degree that could be taught in workplace training or in other placement offers. That will be a decision - I guess that will be a decision that would also have to be cleared by the Australian Nursing and Midwifery Accreditation Council and the NMBA if there's going to be some changes, the structural changes to the undergraduate degree. We see those difficulties and that's why we are suggesting that the Commission could consider a dual degree that provides comprehensive mental health training as well as the general health training.

When I first trained as a psychiatric nurse the professor of psychiatry who wrote our syllabus had always drummed into us that in his view there was one golden rule of psychiatry and that was first rule out a physical cause. It's important that physical health and mental health have the same - the same regard in any - I think in any sort of health practitioner training.

PROF KING: Can I just follow up on the – you mentioned the three and a half – the combined degree. Have you talked with any educational institutions about that? Because my impression is that the university sector tends to be moving away from those sort of combined degrees. So again, I wonder if you're pushing against the tide.

MR SHEPHERD: We may well be. We – we haven't actually discussed that with the institutions at the moment, but we are looking at next year to having what we call a (indistinct) body's meeting to our – with – where we will invite heads of faculty of nursing and (indistinct) faculties have to come and join us in a – like a round table discussion about, you know, potential changes that could occur. And also the research that will need to go to underpin that.

PROF KING: All right. Good.

MS ABRAMSON: Thank you. And thank you for the comments that you made. They're very helpful. Two particular issues. We've heard a lot about stigma and stigma has been a reason why nurses are discouraged from mental health nursing. So really interested in the type of proactive things you might be doing within the union to encourage people to take up mental health nursing.

MR SHEPHERD: With – as a union, we have an annual delegate's conference every year at those delegates' conferences motions are put forward for voting. There's about 350 delegates usually attend those conferences. We've – the delegates have always pushed for recognition that mental health is a specialist qualification and should have specialist recognition. And at our most recent delegate's conference, a resolution was passed or motion was passed to become a resolution that the (indistinct) of new lobbies for the establishment of a chief mental health nurse for Queensland.

We've been looking at the work that the Chief Mental Health Nurse in Victoria has been doing where there has been standards set, there's been scholarship programs, we would like to replicate that in Queensland and that's part of the resolutions that have been passed at our annual conferences.

MS ABRAMSON: So you think a position like that is a really good public statement of the importance of that part of your specialisation?

MR SHEPHERD: It's a public statement, but the work that goes behind that position that establishes that, mental health nursing is really a specialist role. You know, we look at nurses, midwives, you could have a third specialist role that's mental health nursing. The problem at the moment is that we don't know how many nurses working in mental health have a qualification in mental health. I recently wrote to the Australian Institute of Health and Welfare. They're asking that when they do their study – sorry, when they do their survey of nursing registration, when we do that renewal, there's a box that asks what area of practice you're in and one of the options is mental health. So what we've asked is that when someone clicks on mental health, there'll be a separate drop down box asking do you have a qualification in mental health nursing.

The other things we look at too, is that there's not – that there's not just the graduate diploma in mental health nursing that's offered to increase someone's skill and experience in mental health, you've also got a diploma of mental health, you've got a grad cert in mental health, so there are a number of options for further training in mental health that would be of assistance to all the nurses and midwives.

MS ABRAMSON: Just with that workforce point, we'd really welcome a further submission from you and particularly – I mean particularly what you've said, but that point about the fact that when people fill in the form, it doesn't necessarily say what the specialisation is in mental health because we've heard that from other people. They've said to us we can't really see the totality of the workforce that would be really helpful. Thank you.

MR SHEPHERD: Thank you.

PROF WHITEFORD: There's some nurses working with mental health qualifications and not working in mental health that we wouldn't catch because they – they've left. And they've moved into another area of nursing.

MS COX: There is a lot of nurses that with mental health, myself, I've got a masters in mental health nursing. When we've changed from state-wide registrations to APRA we lost our endorsement as mental health nurses.

PROF WHITEFORD: Because?

MS COX: I can't answer that.

MR SHEPHERD: That was a decision made under the National Registration and Accreditation Scheme that there – that on the implementation of that scheme on 1 July 2010, the endorsement that was provided for mental health nurses would no longer exist.

PROF WHITEFORD: It was a state endorsement, was it, originally?

MR SHEPHERD: Yes. Each state - - -

PROF WHITEFORD: And then when it went national - - -

MR SHEPHERD: Most states had endorsement.

PROF WHITEFORD: Right.

MR SHEPHERD: But when it went national, that endorsement was lost because my understanding is that the position of the Board was that the endorsement would be retained – was particularly for nurse practitioners who have gone on to do a master’s degree and be a nurse practitioner, but also for rule and isolated practice endorsed nurses and they were the only two I believe that had endorsement in nursing. Mental health lost the - - -

PROF WHITEFORD: Sorry, sorry, we interrupted you just then. You were telling us?

MS COX: That’s all right. So yes, when I came into mental health nursing and I’ve – and to the statement before about our workforce and yourselves asking about what we’re going to drop from uni, when I went through my uni degree, I knew that I wanted to be a mental health nurse, so I went through cardiac, I went through ED, I went through all the things that I didn’t want to do and I still ended up as a mental health nurse.

To drop something and if I went back into general nursing, I would have to redo all my cardiac and all that, because that’s not something I’ve done. So I think the same for mental health nursing and our mental health acute units, now, we have a lot of general nurses that have no mental health training, increased violence, increased patients not getting the service that they or the treatment that they should. All due to inexperienced training.

PROF WHITEFORD: One of the reasons we recommended the undergraduate mental health nurse degree, so I know you might – it’s going to be a bit tricky with your colleague sitting on your left, but what do you think about that? What are the pros and cons from your point of view?

MS COX: I don’t think it’s – I don’t think it’s enough.

PROF WHITEFORD: Not enough.

MS COX: I agree with the QNNU when they say yes there’s – yes it has a place, but I don’t think it’s enough.

PROF WHITEFORD: So just take that a bit further. So it’d be enough – because what I heard your colleague saying – what tony said was that a lot of nursing is - mental health nursing is about physiology, it’s about the – the physical condition looking like mental health or comorbidity. Is it not enough because that – the mental health undergraduate degree may not get enough of that side of the nursing?

MS COX: It's – it's not like, with – currently, we have a transition and practice for mental health nurses. I did that myself when I did my masters. What happens now is that our undergraduate nurses, they come in, and look, there's a place for all nurses in all departments, but they come into and they utilised the mental health wards. The undergraduates? They don't have the experience in mental health nursing and it is a specialised area. You've got to be watching out for so much more. And I just don't think placing them in an undergraduate capacity is enough. I think we need more.

PROF WHITEFORD: Yes. Can I get one more in?

PROF KING: Please, yes.

PROF WHITEFORD: So just on that, we've also heard that putting a nurse in an – with no mental health background and no further, firstly, is it her first exposure to mental health in an acute inpatient mental health unit? Might be something that might turn them off mental health nursing? Because that can be, as you said, a very, very challenging environment.

Are there other placements that are being offered as far as you know other than sort of an acute inpatient when it's in hospitals for a placement in mental health nursing?

MS COX: Not that I know of. And in your diploma, in your Bachelors, you used to have four weeks in a mental health unit. Now, it's – or a mental health facility – now it's two weeks and it's optional. And it's not enough. And then they come and they do a like, the undergraduate, they come into a ward and they're not trained in occupational violence, they're not trained in psychotherapies and it doesn't matter medications have their place, but without the psychotherapies, you may as well be giving them Aspirins.

And so if they're not trained in the end of that, they're not trained to sit down and talk to patients, they're not trained to watch out for symptoms when people were decompensating and – or when they just need someone to talk to. So we're band-aiding things, we're sending them back out to the community without any of the life skills that they need to survive in the community.

MR SHEPHERD: Then – sorry, and talking to mental health patients can be quite challenging and you need the skill and knowledge background to be able to converse and gain a rapport with your mental health patient and not say the wrong thing.

MS ABRAMSON: Yes.

PROF WHITEFORD: Yes. That's reasonable.

MS COX: And I think that's the biggest thing. With undergraduate nurses that aren't trained they do say the wrong thing and what it goes from is from zero to 100 in two seconds. And then everyone's trying to deescalate and treat that situation back which ends up in assaults, complaints; sometimes the patient is then put under a mental health act because something has happened. And it's all because they – we have inexperienced nurses.

MS ABRAMSON: One of the things that we're really interested in is this idea of internship and where else people could do their training and we've, as you know, got a real focus on getting mental health nurses into the community, so presumably that would be an area too, I mean, I just think about the district nursing in Victoria and you know, they often take students out with them on their placements. So I'm assuming that that was possible. But is it funding or something that means that doesn't actually happen? So it's only placement in acute settings?

MS COX: Look, I've mentored students out in the community, when I worked in the community. So we do – they do come out in the community. I think the thing is – and I was rural and remote so out where I was we also were all trained in psychotherapies. So that's part of it. I think we need to – the students don't get enough and undergraduates don't get enough training in psychotherapies, they get part of their competency is how do we give a depot medication. How do we take a blood pressure? Medications and that is also covered in the general nursing. So we need to be more specific on mental illness. Not the – not our general, because they already do that in their general.

And giving a depot in mental health and giving iron injection and general, it's no different. You're still calculating how much to give, you're still doing the right site, all the other things. They need to be more specific to mental health and like one of the ladies spoke before, psychotherapy and communication, here they go hand in hand, but you can't have one without the other.

MS ABRAMSON: No, that's very helpful, thank you.

PROF KING: Thank you.

MR SHEPHERD: So just on the – I just wanted to mention about the negotiations we did with Queensland Government on getting ratios into improve adult inpatient services.

PROF KING: Yes.

MR SHEPHERD: We've been successful in getting the government to agree that on the morning shift and the afternoon shift, the team leader will be supernumerary. They won't have a case load of patients they'll be able to just be a supervisor and mentor to the staff. One of the bases behind that decision was the fact that many of the nurses working in acute adult mental health units are not mental health trained. They don't have the training, so it creates a much more intense workload for the team leader because he's going to be – he or she is going to be supervising nurses who are not trained in mental health, so it takes – it's a much more active role than the team leader or perhaps a medical or surgical units where all of the nurses are trained in medical, surgical and those.

PROF WHITEFORD: Just before you go, the other – one last question. So you mentioned you worked rural and remote, any suggestions from the union about how incentives that have worked to help encourage nurses to work in, you know, more regional areas or remote areas?

MS COX: When I went out to the community, because I worked in a psychiatric hospital for a time and then I went into the community, I actually had to have my masters before I could work in the community and I had to have looked at all my psychotherapies and had a passion

for that. And now I really do have a passion for that. That is my passion. For going into entice people, having - bringing back our endorsement is one of those things. I am, like I said, I've done my masters. I'm also a credential mental health nurse. And my incentive is \$150 a fortnight. For all that. On - like, yes, I am the CNC so I'm at the top, but I've had to work for that and I know other mental health - mastered and mental health nurses that are still on just RN rates with \$100 a fortnight extra for all their extra training.

PROF KING: Yes. Sorry, go.

PROF WHITEFORD: So financial incentives are one thing, but what you've just said also is that to be a real remote mental health nurse, I'm really into the fact that - that master's degree that has those full range of skills were pretty important to working out there where I imagine you're less supported by teams compared to when you're in a hospital.

MS COX: Yes, and that's exactly right. We - where I - where I started, we didn't have any psych - psychologists or any NGO's. We were those NGO's and we delivered psychotherapies and when I first came in to the community, that wasn't something I looked at. Once I got into it, I really enjoyed it and that's where I think - that's where I think our system, our public system lets us down is where I work, we have - and I'm actually the coordinator of the group therapies. We have a good group therapy program, but a lot of inpatient units don't have that base.

PROF WHITEFORD: We've heard the same from even the psychiatric registrars that you would work with, they give - they'd go through, they do - most of it is the acute inpatient psychiatry, yes.

PROF KING: Yes, I understand. Okay.

MS COX: Thank you very much.

PROF WHITEFORD: Thank you.

PROF KING: Let's break for lunch now and we'll reconvene at 1.15.

LUNCHEON ADJOURNMENT

RESUMED

PROF KING: Okay, ready with the transcript? Okay, let's get started again, and thank you for joining us. If you could state your names, the organisation that you represent and any opening comments that you'd like to make.

MS REYNOLDS: Thank you. My name is Rebecca Reynolds. I'm the Chief Executive Officer of the Queensland Council for LGBTI Health.

MS MORRIS: And I am Sally Morris, the LGBTI mental health coordinator at the Queensland Council for LGBTI Health.

MS REYNOLDS: Thank you very much for having us here this afternoon. We'd like to begin by acknowledging the traditional custodians of the land that we're meeting and working on today, the Yugara and the Turrbal People and pay our respects to Elders past and present, and we have the very great privilege and respect of working with so many emerging leadings from within Aboriginal and Torres Strait Islander communities in Queensland and to be really guided by their work, and we again bring that guidance into the room today so that that knowledge is embedded in what we're here to talk about today, so thank you very much.

Thank you for the opportunity to present to the Commission this morning. Our statement today will pertain to lesbian, gay, bisexual, transgender, intersex, queer, sistergirl and brotherboy people and other sexuality, sex and gender diverse people which we will collectively refer to as LGBTI people and communities.

Whilst a number of LGBTI people live in urban settings in Brisbane, the Gold Coast and Cairns, there are also large numbers of LGBTI people living in regional, remote or very remote parts of Queensland, and Queensland is a geographically decentralised state with large numbers of people living out of urban settings. The decentralisation impacts on the ways our communities belong, communicate and become connected across Queensland.

LGBTI people live in every part of Queensland and we are mothers and fathers, sons and daughters, aunties and uncles. We are diverse people and our lives and relationships to each other and our communities are equally diverse. We made significant contributions to the cultural, economic, social, artistic and sporting life of Queensland.

Sally and I speak to you today as representatives of the Queensland Council for LGBTI Health, formerly the Queensland AIDS Council, which is a Queensland state-wide non-profit community-based health organisation focused on providing quality services that enhance the health and wellbeing of LGBTI people and communities in Queensland. Our organisation was formed in 1984 and has over three decades of experience working with our community to deliver peer-led health services and health promotion that is community based.

We receive funding from both state and Commonwealth governments for some of our work, generate our own income and also rely on the contribution of volunteers, donors and other supporters from the LGBTI and wider communities to deliver our services. This volunteer contribution in particular cannot be understated and indeed our organisation would not exist if it weren't for volunteers and a peer-led workforce.

We know particularly in a state like Queensland, which encompasses Cape York and the islands of the Torres Strait, that the distribution of mental health professionals is skewed to the cities, and Australians living in rural and remote areas may have very limited access to mental health treatment, care and support. People who work in mental health services are among the major strengths of the system, but there are significant shortages in supply and difficulties with distribution of these staff. Peer work does not replace clinical or other services, but instead can complement and support existing mental health and community care services.

Exploration of new and emerging roles is one way to support service delivery, but peer workers have been identified as being able to contribute to better health outcomes and are employed in significant numbers in countries similar to Australia and indeed across Queensland. As an organisation this requires a vast ability to think differently about the way in which we provide our services in order to support this workforce and to better increase our ability to work with those LGBTI people and Queenslanders living in rural and remote areas of our state. The capacity of mainstream services to support out LGBTI communities is limited by a shortage of skilled health and service delivery workers.

Given this, we need to move to a system that coordinates skills and services to ensure that every interaction between LGBTI people and health and care providers achieves the best possible outcome with the scarce financial and human resources available.

Currently services and supports provided to LGBTI people and communities are characterised by discrete projects, resources or information across different organisations which creates significant fragmentation and barriers to improving an individual's health and wellbeing.

At a systemic level, this lack of coordination creates significant challenges to understanding both needs and opportunities, and a change to this approach could support better population health surveillance, guide policy, inform and lead service planning and create significant cost saving innovations and significant return on investment through shared operational decision making. The need for centralised points, or what I'll call a hub and spoke model of coordination, would reduce the risk of duplication, reduce sector fragmentation, better utilise financial and human resources and create new solutions that can be integrated and scaled up across a state-wide continuum of care.

In addition to a need to think about different ways to maximise the scarce resources available to improve mental health outcomes for Queenslanders, we support that there needs to be a strategic commitment to underpin the development of a peer workforce in Australia. From our history at the Council, it is clear to us that peer-led interventions on mental health have the potential to offer a good deal to LGBTI people and it also is the case that those who are leading the interventions have much to gain also.

MS MORRIS: So research has consistently demonstrated that LGBTI people have high rates of mental ill health. LGBTI people are twice as likely to be diagnosed and treated with a mental health disorder, six times more likely to meet the criteria for a depressive episode and twice and likely to meet the criteria for an anxiety disorder, score moderate to high levels of psychological distress on the Kessler Psychological Distress Scale, and are six times more likely to have recent thoughts of suicide.

The sub-populations that make up LGBTI communities have also been shown to have even higher rates of mental ill health. Specifically, transgender and gender diverse people are five times more likely to be diagnosed with depression and they're nearly 11 times more likely to attempt suicide. Intersex people are seven times more likely to be diagnosed with post-traumatic stress disorder and LGBTI young people aged 16 to 27 are five times more likely to attempt suicide.

These mental health outcomes are directly attributed to the systemic exclusion, stigma and

discrimination. LGBTI people who have directly experienced discrimination have higher rates of mental ill health than those who have not.

However, these are not isolated incidents. The Australian Human Rights Commission reports that 72 per cent of LGBTI people experience violence, harassment or bullying on the basis of their sexual orientation, gender identity or intersex status.

Research has also show us that transgender and intersex people experience even higher rates of abuse once again. Importantly, the high rates of mental ill health of LGBTI people who have not directly experience discrimination shows the direct impact of unsupportive social and political environments can have on a group of people.

Stigma towards LGBTI people is entrenched in our social, cultural and political climate and is perpetrated by our families, communities, leaders, religions, legal systems, medical professionals, educational institutions and media, to name a few.

Structural stigma and the discrimination it facilitates and the resulting trauma directly affects LGBTI people's social and economic participation. This results in reduced contribution to productive and a higher cost to the economy to provide mental health care.

MS REYNOLDS: We'd like to provide to you some background which is informing our recommendations today based on some state-wide consultations that our organisation has done over the last six to 12 months.

Within Aboriginal and Torres Strait Islander LGBTI plus sistergirl and brotherboy communities, our 2 Spirits program which is an indigenous led program for LGBTI people and populations alongside the Queensland Council for LGBTI Health has conducted a state-wide process to try and identify why rates of suicide and self-harm are so high within First Nations populations of our state.

The key theme that came out of those consultations was around racism and discrimination. Participants shared and emphasised ongoing violence, bullying, harassment and discrimination experienced by many without our communities based on their sexual orientation and gender identity. Participants talked about how discrimination is interlinked with and can also exacerbate the effects of racism, i.e., a double discrimination being LGBTI and being black, which in turn leads to increased isolation from other LGBTI communities or mainstream communities and for many an increased misuse of substances, an increase in mental health issues, homelessness and risk of suicide.

Participants also reported high levels of discrimination and lateral violence within some communities, especially where the visibility was negligible or non-existent.

Sistergirls and brotherboys and LGBTI Aboriginal and Torres Strait Islander people living within this context are in survival mode. They are not thriving and this was emphasised as normal trauma behaviour. Overall, participants reported that people are on edge constantly. For example, participants reported that during the Townsville consultation, in their words, the fear was off the scale for people in Townsville. They shared many experiences of racism and discrimination within the service sector, for example, that has resulted in difficulties to

accessing a range of basic services including health care and mental health services or non-engagement with services altogether, rendering these services inaccessible.

Consultations highlighted how many Aboriginal and Torres Strait Islander LGBTI sistergirl and brotherboys are faced with healthcare professionals who are ill-equipped to provide them with culturally appropriate services and support. Participants provided some examples, including medical professionals asking what gender they were born rather than honouring the gender they are. Other examples reported included a GP laughing at them for talking about a trans, transitional operation and another GP exposing them within a group of students for having had a transgender operation.

As a result, healthcare services are considered unsafe spaces for many Aboriginal and Torres Strait Islander LGBTI sistergirl and brotherboys who feel frightened and in fear of being judged and traumatised through visits to such services. In turn, feelings of vulnerability and stress are intensified and we were told that hospitals, doctors, surgeries, community health services are amongst the worst places for them. Some participants reported that indigenous healthcare workers working in indigenous medical services could also be cruel, particularly in very small communities where overall social stigma and discrimination exists against Aboriginal and Torres Strait Islander LGBTI sistergirls and brotherboys.

The intersection of sexual and gender identities and discrimination within the service sector compounds social detriments of health for this group and participants stress that the service sector needs to be held accountable for their service provision to these communities.

MS MORRIS: We'll now speak to the background information regarding intersex people in communities. As an organisation we aim to work alongside peer led organisations wherever and whenever possible, resourcing - wherever resourcing limits our meaningful contribution to a body of work and this is true for work for the advocates in supports and needs of intersex people. We respectfully suggest that the Commission and its deliberations are informed by our intersex led organisations in this piece of work, Intersex Human Rights Australia and Intersex Peer Support Australia. They alongside other intersex advocates have done extensive work on the needs on intersex people, their families and carers, including an essential piece of work known as the Darlington Statement.

In particular we acknowledge the long term physical and psychological implications of harmful and continuing medical practices and limited access to support and peers. We support the statement that current forms of oversight of medical interventions affecting people born with variations of sex characteristics have proven to be inadequate. We note the lack of transparency about diverse standards of care and practices across Australia and New Zealand for all age groups. We note that the Family Court system in Australia has failed to adequately consider the human rights and autonomy of children born with variations of sex characteristics and the repercussions of medical interventions on individuals and their families.

The role of the Family Court itself is unclear. Distinctions between therapeutic and non-therapeutic interventions have failed intersex populations. We call for the implementation of advisory bodies to develop appropriate human rights based lifetime's intersex standards of care, with full and meaningful participation by intersex community representatives and human rights institutions. We affirm our commitment to the Darlington Statement, which was developed by

intersex organisations and advocates in 2017 which articulates the human rights demands of people with intersex variations in Australia and New Zealand. We actively acknowledge the distinctiveness and diversity within intersex populations and respect the intersex movement without tokenism or co-opting intersexes away to other ends.

We commit to adopting human rights and legal reform health and wellbeing peer support education awareness and employment objectives of the statement, alongside other allies and intersex organisation and advocates. We recommend to the Commission that the Darlington Statement and the Australian senate report on involuntary and coerced sterilisation of intersex people is taken into consideration.

MS REYNOLDS: Some background on trans and gender communities. Within the Queensland Council for LGBTI Health we run an organisation, community organisation called Many Genders One Voice and it's informed by a state wide advisory committee made up of people with lived experience to guide and provide strategic advice on the development of our programs for the gender and - trans and gender diverse communities. They also provide guidance, understanding and recommendations to improve access to health services for trans and gender diverse people across Queensland. Through this mechanism and others we've identified a number of ways that can assist in addressing systemic barriers to mental health outcomes from which we will reference in our recommendations.

However, I wish to read verbatim a statement received from a mental health professional, who has a trans history, based in Cairns. He says:

It's very hard to know how to put this succinctly into words and how I can encapsulate why it's so important that we work towards gender affirming surgeries being covered in line with all vital surgeries for Australian citizens. Do I use my example? I am a tax paying professional, I have been my entire career. I dedicate my life to working alongside disenfranchised people from all walks of life, including military and front line responders. My client group are primarily heterosexual men. I am a 43 year old man who had to afford the \$150,000 that it took me to have my lower surgeries, otherwise I could not have chosen to keep living.

Eventually I have no doubt I would have suicided as being trapped in a body that is not my own was for me untenable. I was not mentally unwell, in fact I continued to work throughout. I was, however trapped by a system that both paternalises me by ignoring my dysphoria and then tells me in the next breath that if I do suicide it's because I was unwell around being trans. No, I was simply being denied access to surgeries and being told by the government they are cosmetic. Of course, then for those of us that sit in this professional work we are in a double bind. Do we acknowledge the suicidality and buy into the paternalism or do we deny it and deny our needs?

So for me I made it happen, the surgeries. This meant for me living in hostels for two years to save. It meant personal loans. It means I now have no super to speak of. It means, however, the end of my dysphoria and the ability for me to advocate continuously. For other professionals I know, paramedics, law enforcement and others, they have done similar things, lived in their cars, couch surfed, asked their families to take out loans. But here's the rub, not everyone has the ability to change their circumstances like me. What

do I tell the suicidal 14 year old young man with Asperger's who will likely never make the income I do about our government?

Do I tell him they don't care about his access to surgeries and that he'll never be able to afford it so it's best for him to suicide now? Or do I tell him that instead of paying for his surgeries he will instead more than likely cost the government the same amount in mental health care, drug and alcohol rehabilitation or incarceration costs? Do I tell him about the reams of evidence from overseas that direct access to surgeries makes a profound difference in the mental health of the gender diverse community, that the choice to choose is a grounds to a foundation of good mental health? Do I tell him he was unfortunate enough to be born in Australia?

Trans and gender diverse people suffer from a mental health epidemic which is directly linked about their inability to choose what access they need to surgeries and medical intervention they require. I can state these things because I am fortunate in that I have an education and I'm not employed by an organisation which is reliant on government funding and I do not have to toe a party line. The only thing I want to change is the suicides and poor mental health outcomes which are directly related to the inability for the gender diverse public to access the surgeries that they need.

Not everyone needs surgery, no, but a lot do and I think one of the unacknowledged fears is that if the government recognises this need they feel like there'll be an enormous cost attached. I think that the point I am making is that there is already a cost. It is young lives. It is poor mental health outcomes. It's felt in other corners of the sector. It's lack of further connection to positive life outcomes. Not everyone has the ability to work through when they have battling gender dysphoria. My friend said to me the other day that like me now that we are done he just wants to shut down his phalloplasty groups and move on with his life, but he can't because he knows how many suicidal young people are in that group living vicariously through us, hoping one day things will change. I too feel the same.

I also understand that for many of our trans sisters, many of the same problems apply. The public, however, are unaware of this crisis as the vast majority of them think these surgeries are already funded under Medicare. I am happy to support my fellow Australians through my tax paying dollars. I just want the same right. I want a day where the people that come after me don't have to choose between a house or a penis. Where it's okay for them to build into their future planning, the leave they require to access the help that they need. Where the allied health systems can adequately prepare them for the challenges ahead.

Where the sole barrier is not the government's stance on healthcare. Where I actually have a real promise and responsive help and support for the young people and families in my therapy rooms. Where they don't have to choose between saving for a potential child or a surgery rather than a university degree, a first home or a trip overseas. In short where we can enjoy the rights of everyone else.

MS MORRIS: As the - - -

PROF KING: I'm just cautious also about time, because we'd like to have some questions.

MS MORRIS: Yes. No problems.

MS REYNOLDS: No problem.

MS MORRIS: As the mental ill health of LGBTI people is clearly caused by their social environment we recommend applying a social determinants framework to develop a comprehensive and integrated response to improve the mental health of LGBTI peoples. So we'd like to propose the following recommendations: (1) create a supportive environment where LGBTI people experience social inclusion. This can be supported by promoting the reduction of stigma through stigma reduction campaigns, media communication guidelines and education about rights protected for LGBTI people under the Sex Discrimination Act. Schools being a safer environment to facilitate LGBTI people to remain engaged in their education, and therefore support their participation in employment.

Enabling early intervention of gender diverse and intersex children in childhood through access to appropriate healthcare and information support for families. Ceasing of medically unnecessary surgeries of intersex babies and children, as per the recommendations of the senate inquiry. Developing a mentally healthy and discrimination free workplaces where LGBTI people can actively participate in employment and remain engaged in the workforce, in particular for transgender and gender diverse people. No legislation to be permitted to facilitate legal exclusion, prejudice or discrimination of LGBTI people, including those proposed in the religious discrimination bill or exemptions under the Sex Discrimination Act. Inclusion of demographic questions in the - that capture LGBTI people in the 2021 census and other ABS population health research.

Number 2, support individual capacity to implement personal health practices and build effective social support networks. This can be supported by adequate income and support that facilitate LGBTI people's participation in the community. Access to long term affordable stable housing that is free from discrimination, abuse and harassment, particularly for transgender and gender diverse people. Funding for and development of LGBTI peer led programs, services and organisations, and facilitating movement between community services and clinical services.

Number 3, facilitate the building of personal wellbeing to develop resilience, manage stress and utilise coping skills. This can be supported by LGBTI people having access to advocacy support in mental health, and particularly in inpatient mental health care units and when discrimination is experienced by mental healthcare professionals. Ensuring LGBTI people are able to access mental health care at the right level, including low intensity support that facilitate early intervention. Transgender and gender diverse people having timely access to gender affirming healthcare. Resourcing a national LGBTI teleweb peer support service, QLife, to provide national 24 hour care to LGBTI people, and the recognition of value of non-clinic supports play in mental health of LGBTI people.

Number 4, ensuring equitable access to mental health care through systemic change. This can be supported by LGBTI people being deemed a priority population in all mental health and suicide prevention programs and ensuring that these responses address the specific risk factors

experienced by LGBTI people. Exemptions for religious based organisations that deliver Commonwealth funded mental health services under the Sex Discrimination Act to be removed, and protections developed to ensure LGBTI people are free from all forms of discrimination in mental health services. Services that receive funding to deliver mental health services to have a contractual obligation to provide services to LGBTI people.

Mental health care pathways for LGBTI people to be coordinated and integrated and to receive timely access to appropriate healthcare. The healthcare workforce to have access to quality LGBTI professional development, education and training and incentives to implement good practice frameworks and standards of care, and an investment in LGBTI mental health research, including the inclusion of LGBTI demographic questions in mental service data collection and the evaluation of these services to provide healthcare.

MS REYNOLDS: In each of these recommendations we propose that they are developed and implemented with a contribution of LGBTI people themselves. This cannot be tokenistic, but LGBTI people must be meaningfully included in the planning, development, implementation, delivery and evaluation of any and all legislation, policy, strategy, frameworks, programs, research and services that affect our lives. This inclusion in these will assist with the identification of systemic stigma and will ensure that mistakes of the past are not repeated, where damaging practices that increase rates of mental ill health are imbedded in the system and structures of our society, thereby increasing LGBTI people in economic contribution and decreasing the cost of their resilience on the government for support. Thank you for your time today.

PROF KING: Thank you. If I can just start off. So within the health system itself, I notice - I think it might have been the fourth of the recommendations, but sorry I didn't put the numbers down next to them. So a priority group for LGBTI, a priority group for mental health services and you talk about contractual obligations and so on. To what degree does that need to go hand in hand with stigma reduction in the mental health services? I mean we heard already at broader level that within the health system the people who have mental illness face discrimination from the broader health system. Now with LGBTI community, to what degree - you can put the rights there, you can put the obligations there, but as long as you still have that stigma, how do we get that holistic response, I guess, within the health system?

MS MORRIS: I agree that they need to be hand in hand. That often actually I find in our work that when we educate people around stigma reduction and about the impact of stigma, therefore becomes an interest and how do we better support LGBTI people. So I think it is actually - it's all pieces of the - different pieces of the larger puzzle that education around LGBTI people's mental health outcome results in lower stigma, which results in better services, which results in better mental health outcomes for LGBTI people.

PROF KING: Okay, and where with the peer workers - and you've mentioned peer workers quite a number of times on the way through, where do you see them fitting - and again I'll focus on the mental health system, would you see - well, no, let me not try and second guess. Where do you see them fitting? How do you see the peer workers integrating in with those - the health system?

MS REYNOLDS: I think - sorry, what I just said was imbedded - - -

PROF KING: Yes.

MS REYNOLDS: - - - as opposed to integrated.

PROF KING: Okay.

MS REYNOLDS: But in the same way we would design programs for Aboriginal and Torres Strait Island communities that are led by locally delivered solutions, elders and organisations within those communities, the same can be extended out when we're talking broadly about our LGBTI communities, that the make-up of the system and the structure is volunteering and that where our systems and services fall down is where people get burnt out because there is not a structured way to kind of create like a career path effectively of volunteering or a system of standards that support within a mental health space.

PROF KING: Yes.

MS REYNOLDS: When we're talking about peers is that people who have also got a lived experience of mental ill health or is that just people who have an LGBTI peer led experience? So I think a lot of work needs to be put in to understanding the overlaps within that space. So that then, you know, as Sally said that stigma starts getting reduced because when it's led by someone and you're hearing their story and you're starting to breakdown your own preconceptions, I guess, then that's when we start to breakdown those bigger pieces of stigma and discrimination within the community, and I think that's kind of what I was going to say before is I think within every single one of our funding agreements, and I can say this over a number of years, stigma and discrimination is in there as one of our - breakdown stigma and discrimination is in there as one of our deliverables.

PROF KING: Yes.

MS REYNOLDS: And when we think about that, effectively we are saying to LGBTI people and populations that they need to get the resilience so that they can walk out of their door every day and face the thousands of micro aggressions that are going to come their way because of, you know, the bigger and broader picture.

PROF KING: Yes.

MS REYNOLDS: The only way that that's going to be addressed is by individuals leading the response so that people start to see people as opposed to some spectre that's portrayed in a media and a document as another way or a different way.

PROF KING: Okay. Just thinking again about practical implementation, I don't know if this is a good idea or a bad idea, so please tell me, but we've talked about care coordinators, care navigators, people who can help those who have mental illness and trying to work their way through the system to help them in that process. Would it be a good idea - and I'm happy if it's a stupid idea so please tell me if it is - if you know a person who was LGBTI could say "well actually I want a coordinator that is LGBTI" or at least has an understanding, has the empathy, would that help? Would that - or is it - I'm worried because again it's sort of saying, well -

I don't want it to be that you end up getting, well, you're now in the LGBTI box over here, and I get worried it might do that.

MS MORRIS: Yes. I think certainly people would like the option. I think - certainly I think not all LGBTI people want to access services from LGBTI organisations, but certainly a portion do. When LGBTI people are accessing support from LGBTI people, an LGBTI organisation, there is an assumed level of knowledge that they don't have to explain what is my sexuality, what is my gender, what is my intersex status. So there's a shortcut, and there's also an assumption that they're not going to experience stigma and discrimination. So you sort of - you skip over ten different things that are happening when an LGBTI person accesses a non-LGBTI service and it helps an LGBTI person receive the support they need quicker, and without having to navigate stigma and discrimination. In saying that some LGBTI people certainly - - -

PROF KING: Choose not.

MS MORRIS: - - - choose not to.

PROF KING: Yes.

MS MORRIS: But I believe that where we are in society at this moment in time, I think it would be great to get to stage where that wouldn't be necessary and that would certainly be our intent to get to. But I think where we are now in our society, the inaccessibility of the majority of our mental health services that LGBTI people need that extra support to navigate. Probably even more so than people who aren't LGBTI, because not all the services available are accessible to LGBTI people. So not only are they navigating a complex system, but they have to determine which one of these services will - is safe or not safe today. Yes.

PROF KING: Okay. Good.

MS ABRAMSON: I have just one question, and bearing in mind we've got a few other witnesses to hear from; I don't mind if you take it on notice. We're particularly interested in young people and getting services to young people, and you know what the trajectory is for young people in mental health. So any ideas about how we can get services to them, we would really welcome that.

MS REYNOLDS: I'm absolutely happy to take it on notice, but also very pleased that you have the Queensland PHNs speaking before you this afternoon. Within Brisbane North PHN over the last 18 months, they have been running the National Suicide Prevention trial.

MS ABRAMSON: Yes.

MS REYNOLDS: What has been amazing about that is that, for young people in particular, services are funded at a specific youth specialist service. Capacity building is provided to a number of different schools within the region as well, working with teachers and parent groups and young people, and there are very specific youth support groups which are providing coordination pathways for those young people, and we're seeing amazing outcomes from that.

MS ABRAMSON: Would you, in these programs - and I'm making an assumption here, and correct me if I've got this wrong - they're broad programs for youth, but they're designed in such a way that if people come forward with issues in how they feel about their sexuality, their channelled to other services. Is that how it works?

MS REYNOLDS: Education around respectful relationships and respect for yourself, with very clear messaging around LGBTI identities and feelings, and I think beautifully summed by our health minister this week when he put forward the proposed legislation around banning gay conversion therapy, when he spoke to the fact that saying to any young person that they're potentially wrong or need correcting for their sexuality is abhorrent and has no place in the health system in Queensland.

MS ABRAMSON: I'm making the assumption, given that you gave such an articulate presentation, that you'll putting in a submission to us?

MS REYNOLDS: Absolutely.

MS ABRAMSON: Yes. Thank you.

PROF KING: Thank you very much.

MS REYNOLDS: Thank you.

PROF KING: Next, Ms Anderson. And welcome. If you could state your name and any organisation you represent here, if you're representing an organisation, and any opening comments you'd like to make.

MS ANDERSON: My name is Beryl Anderson. I'm a lived experience, complex trauma mental health survivor. I'm representing myself. I've just had a life experience, so I am - this is really nerve wracking for me, so bear with me a bit.

PROF KING: No, no, no. Please take your time.

MS ANDERSON: Firstly, I'd like to thank the Productivity Commission for having an opportunity to voice my story and hope that my experienced adds to the conversation and may identify areas that may have slipped through the cracks, because that kind of like represents my whole life. I kept slipping through the cracks because I didn't quite meet any criteria, although I met all of them, and I related to a lot of what was - happened today, and discussing today. But I'll get back to my description, sorry.

MS ABRAMSON: Take your time. It's fine.

MS ANDERSON: Normally, I would have a support person, but I didn't have the opportunity to actually get someone to come with me, so I apologise for that. I'll just read my notes. They may be a bit distracted.

PROF KING: That's fine.

MS ANDERSON: I met the eligibility for a disability allowance, and so it was 1990, but continued to fail to meet the eligibility to meet NDIS. I've been on the rollercoaster for the NDIS application process for three years, and the very day that I get a notification of denial, the very next day I get a notice from the same organisation to say, reapply. And I still haven't quite met the eligibility, and they still don't know what to do with me and I'm still going through the process.

Often the clinical evidence of mental health does not fully reflect the documents and the obvious mental health does not reflect the true picture of the mental health conditions, impacts, and effects that it has on both the individual, the people who work with them, and also the people who live with them. And I can relate to that, because I was a carer for my mother who had mental health issues. She relied on the public system. The system failed her because she had someone at home. So she wasn't getting the full help that she had, and I couldn't look after her fully. We couldn't afford the care.

And so what ended is she got part packages that didn't really help her. That's sort of like treading water. And because my mum was getting help, I couldn't get help, and so my mental health sort of like evolved as a relationship of that. My whole life has been a mixture of different areas of domestic violence, workplace harassment, where injuries or conditions from employment and having mental health issues resulting from that, and then not being able to get employment, and losing employment because all of a sudden you had mental health issues. Digressing.

To me, living with mental health has provided a diverse range of experiences that have been both challenging to navigate and frustration with the delivery of the practices. I have seen many changes with the sector of mental health and the impact of fragmentation of sector practices, competition based funding models changing the face of the service delivery both public, community sectors, and the private sectors.

I am the result of the lack of access to early crisis support. Regardless of payment plan, through financial disadvantage and reliance upon public funding, I have been forced to make choices about how, what, if, and when I can seek help. Living with complex mental health - living with complex trauma mental health to me means not presenting with appropriate signs, symptoms, reactions, and responses at the clinically appropriate time.

Further, the clinical assessment process and the constant changing of clinical language and labelling has resulted in the process of clinical care now a key trigger to my episodic condition. This can be evidenced by my transitioning across to the NDIS, because I was actually on the verge of getting back into the workforce before the transitioning in Queensland took place. Since then, I've lost access to my continuity of care network.

I've also had the ability - I've actually been told by my doctor that he's very concerned about me. I'm now in crisis because I've gone backwards and not forwards. Having said that. So the challenges faced with trauma impact and employability, I have experienced different forms of institutional and/or organisational abuse due to neglect, indifference, or reluctance to support work-related injuries that require time and workplace support to effect recovery.

My experiences within the workplaces have been that employees with work-related mental health injuries were considered flaws - flawed and a burden on the physical balance defined by insurance coverage, and found ways in which to either dismiss you or compel resignation with lasting effects upon confidence, and scars that are difficult in healing. For me, I have found the public, private, and community health support and mental health services can be difficult to access due to location and social economics upon which a person can be assisted, especially if mental health trauma is involved.

The process of assessment can be dehumanising and devaluing. A person can be defined by one's ability to contribute to society. A cost burden rhetoric. And that the eligibility assessment procedures defines you and the support needed by the cost of the support services and the ability to pay direct, upfront fees, more often now with gap fees, and/or stressed public funded practices within catchment areas for access and continuity of care becomes very prohibitive.

Somehow, the human aspect of service support is being driven out of the sector through costs prohibition and insurance regulatory practices. The impact of the NDIS on the community health services sector resulted in unintended consequences. Sorry, I'm just - - -

PROF KING: No, no.

MS ABRAMSON: Take your time. It's fine.

MS ANDERSON: I'm trying. Okay. Access to medical information - sorry. Difficulty in accessing affordable and coordinated early crisis care outside of clinical practices, part of the holistic approach to patient-centred care, doesn't always require - how do I say this - it doesn't incorporate alternative practices. It doesn't recognise it, so it's all about coding and funding coding. For example, one of my mental health conditions is as a result of when I had a non-Hodgkin's lymphoma. So it interferes with your nervous system, and so what happens is, I have a compromised immune system and a compromised nerve system.

It doesn't have any awareness of past, present, future, or (indistinct) or physical, or emotional or mental. It just recognises pain. It recognises past experiences. So it's more about chemical fluctuation and how the body then reacts. So it's like reactions and responses. Saying that, one of the side-effects is that if the body's under physical or biological and bio-mental stresses, I can randomly collapse. So it's like a crash and burn effect for me, and one of the regional indicators is like if you ended up in hospital, you would have a blood test, and that would tell whether or not you had that - whether or not you had that condition.

Under the current funding structure, that blood test is no - because they deem it to be a faint, and not necessarily listening to you, the underlying body doesn't allow for blood tests under that particular condition. So you are just left in emergency or intensive care with monitoring, and they don't talk to you, they don't experience with you, and you end up having this - and taking the stick where you're challenging their processes, and you're not getting the assistance that you need, and sometimes you end up lying in a hospital feeling trapped.

So, to the point now where I am reluctant to go to the emergency centres because you're either kicked out, because you're told to leave when you're not ready to leave, or you're just not sick enough to get the right help, or you're too well to get the appropriate help. And so they don't -

it doesn't allow the system - I'm not blaming the individual. I'm blaming the system and the process of funding versus coding. And it doesn't integrate with - out of outreach or what I call within reach, outside assistance.

Like, if your carer goes does a lot more, living with you, they won't - they current privacy laws don't allow them to talk to your carer if you're in times of crisis, because that breaches the Privacy Act. Or they don't talk to the - or they don't ring up the GP who may have been seeing you, or looking at that past history. It's basically, they don't look history or - sorry, I'm getting carried away here.

Moving onto consent, informed consent. The privacy law is often used to prevent you accessing your medical health records or being able to talk to find out, and it's all about trial and error. But when you're in a crisis, trial and error's the last thing you can deal with, and it certainly is the first thing that you're not going to be able to do, because trial and error means research, and that's part of the problem - the only problem I have with the NDIS plans, and the peer support that I've been coming across, is against the process system.

It's all about developing their workforce. Even though it says patient-centred, it's about developing their service provision workforce rather than actually looking at the individual. I'm one of those people that has a blend of clinical and non-clinical, but the system doesn't recognise non-clinical, because it's evidence-based. Evidence-based therapies is great if it works for you, but sometimes for the individual, it's a combination.

For example, for me, going through a systematic learning process and using educational VET training, and teaching me or showing me through coaching and mentoring practices can actually get me through the clinical process. But it's not recognised as evidence-based therapy, so therefore it's not considered to be part of my process, and if I rely on that, therefore it becomes non-eligible for NDIS, and you can't get NDIS because you're not meeting their tick box requirements of medication, six-monthly psychological reviews.

And if you've got to have psychological reviews from a psychiatrist and a psychologist, and also occupational therapists, which is I want, what I need, which is team management, you can't get that until you're on a plan, or you've hit crisis and you can't get into the hospital, because that sets me off. So I can't get the plan access that I need because it doesn't operate at outreach centres. Sorry, I'm trying not to - I'm trying to keep the floor without diverging.

MS ABRAMSON: No. Well, a number of things you've said to us just reflect - I don't mean just - but I mean other people have given us that evidence. So to hear from you directly, it's really important.

MS ANDERSON: So, in that context, it's like a roundabout rollercoaster ride, and I have been on this rollercoaster since I was 18. My condition has had 17 different labels between the time that I was first diagnosed to the time that I am now. When I was first diagnosed with my condition, it was called neurological emotional behavioural disfunction. Because PTSD was only associated with wartime services. It wasn't associated with trauma based, and the trauma can be domestic violence. Trauma can be based with life experiences.

I've had five near life/death experiences. I've had sexual assault harassment. I've been a victim

of domestic and also workplace and school environment. Every one of them was a case of, where's your proof? Where's your evidence? And if it's you against a group of people, and they've got money and you don't, your social economics automatically disavows you and you're disbelieved. A lot of the people have said, why aren't you? Fear is one of them, and I can give a - I'm sorry if I'm digressing, and I'll try not to.

A perfect example was when I was in grade 2, I was sexually assaulted in the playground, in front of teachers who dismissed the situation because it was girls assaulting a girl, who basically dragged me to the ground, stripped me, and called the boys over to laugh at me because I made the mistake of saying that I was a tomboy. And so their argument was that because there was no sexual penetration, there was no sexual assault. And so I grew - and I was also dragged into the principal's office, because I complained about the teacher not coming to aid, because I was screaming.

They were sitting on my head. They had the jumper pulled over my face. They had my underpants pulled down. Every time they pulled a boy over, they would lift up my skirt and say, is this a boy or a girl, and the boys would laugh, and that to them - and that went on for 10 to 15 minutes in front of a teacher, who did nothing, and said, oh, they were merely playing. And the only difference was, the reason there was nothing taken further, and I was the whistle blower, and I was the one being held to account, was because their parents actually funded the private school, and my parents were charity cases, because I was a ward of the state at that point.

And so therefore, from that perspective, I was to be automatically disbelieved because there was one of me and three of them. One held me down, one lifted the skirt, and the other one held my feet so I couldn't move. In that situation, the principal then turned around and said if I was to ever lie again that I'd be immediately expelled, and I was - if I told my parents, I'd be immediately expelled.

So I lived in fear, and because they got away with it, I spent the rest of the time that I was in that school under - being bullied, physical assault, and at the end of the day, the principal, when I finally had enough and re-complained, the principal turned around and called the whole school out, grade by grade out, and said, she's saying that you guys are harassing her. And so that's what ended up happening. That's just the trauma, and I've lived with that, and they go, it doesn't happen. It doesn't exist. And I could on. I'm just an example of one person. I'm sorry for this.

PROF KING: No, no, but it's important to hear.

MS ANDERSON: I normally can talk about this in third party, which is why I - I have what they call destruction therapy, which is not necessarily evidenced-based. Because that's personal. It's about the individual. Destruction therapy is what works for that person, and the only evidence is for that person. And one of the things that they use is basically what they call VET practices or skills-based learning. Because you're learning something. You're channelling all of that energy into something else, so therefore you can learn and utilise.

So that's where, if you're looking at skills-based, it's incorporated with VET practice into the whole mix. Because the VET sector incorporates the whole lot. You've got VET in your higher

education, you've VET in schools, you've got VET in the workplace. So without that holistic approach, and where they partner with - because at the moment, everything's about competition. This person's competing with this lot of funding. There's no collaboration. It's all about IP protection.

We talk about data. There is many opportunities where there's programs where they talk about - just recently, and off the top of my head, I can't tell you, but normally I can when it's not me. They talk about open, shared data where they all put into a collective pool of data so every person within the sector ends up talking about the data, and so they share, but they also keep their very unique, specific ones for themselves.

And so everyone can access anyone, and then they can use that information for their own case arguments, because that's what the Skills Industry Council used to do, until the government pooled the funding and killed the whole process. They've embedded research into it, but also made community health service cost prohibitive for the provider. NDIS, for example. A lot of good providers have gone under the wayside since the NDIS has rolled in, because it's bled them. Because the other thing that's not taken into account is the accreditation process for professionals. You've got workplace trainers who have to have three levels of accreditation, and maintain that. There's no mandatory requirements for any of the RTOs, or the universities or the workplaces to provide ongoing technical care - ongoing technical development, they only have to provide what are called 'clinical skills'

So, if, as a workplace trainer, to maintain a Cert IV, the requirements are you must marry - you've got to hold the (indistinct) that you're being assessing for, the unit (indistinct) that gives you license to do that, plus work experience or field experience in that area. So if you're working full time, like a friend of mine who's up in Darwin, he's a full time VET trainer. For him to be able to do his technical skills, it's at the discretion of the RTO to do all of his tech skills, yet the requirement says that he must do all of his tech skills to maintain his currency. The RTO only has to provide - - -

MS ABRAMSON: Just excuse us - - -

MS ANDERSON: Sorry.

MS ABRAMSON: We have another Commissioner who's just joined us. I'm very familiar with the vocational education system - - -

MS ANDERSON: Sorry.

MS ABRAMSON: No, no. Don't apologise. So I'm very familiar with what you're saying to me about that, and coincidentally, the commission has another enquiry which is looking at the skill sector, so I'll certainly make sure that we pass - it's on the transcript, we'll pass those comments on for you. But I'm familiar with the issue that you've raised.

MS ANDERSON: The person who can actually speak - when I'm up, if anything, but for you is here, he'll be able to speak better. He's up in Darwin.

MS ABRAMSON: No, I understand your point.

MS ANDERSON: Yes. Sorry, I apologise. But the bottom line is that there shouldn't be competition. For community health services, we are losing the ability to be human. Not everyone responds to e- or digital resources. I'm one of them.

MS ABRAMSON: Yes, yes.

MS ANDERSON: When I'm on a crisis, the last thing I need is a digital resource, because I require that human interaction. I require the ability to measure the person who I'm talking with, because relationships is very important. The other problem with the funding model is that, for me, I can't say that I – because of the nature in which I was a ward of the state, I can't say that I can actually relate to being an Aboriginal or Torres Strait Islander, but the very nature of my child is removed from care, leaves me to believe that I relate much more to their practices and their ability to heal.

Unfortunately, because I can't prove one way or the other I am, I'm – it's difficult for me to access the very practices that they can access, because I can't prove because the funding says, 'if you're not, you can't go there.'

MS ABRAMSON: And it's the point that you made to us right from the very beginning, that you fall between the cracks. You don't need this program or that program, which means you can't get the services that you need.

MS ANDERSON: Because I'm in the two – tick a box, and I'm not appropriate.

MS ABRAMSON: Yes.

MS ANDERSON: So I do apologise for going off.

PROF WHITEFORD: Is there anything else you wanted to say which we'd help as – you know, what would have been different for you to make it have been better? I'd probably need to read the transcript because I missed the start of this, but - - -

MS ANDERSON: That's all right.

PROF WHITEFORD: Just give me the number one thing that would have made a difference, if you - - -

MS ANDERSON: In my situation, since 18 – since I was 18 and I was first diagnosed, I've had the ability, or the luxury, whichever way you want to look at it, of seeing – I first came into the system when - - -

PROF WHITEFORD: Give me the number one thing - - -

MS ANDERSON: I'm getting there.

PROF WHITEFORD: That would have made a difference.

MS ANDERSON: When I first went into the system, there was a system called Commonwealth Rehabilitation Services. There was pros and cons to that: the pros was you had – and that worked with Centrelink, where you actually had an – if you had complexity, you went straight into what they called an intake social worker.

PROF WHITEFORD: Right.

MS ANDERSON: That person was trained in the ability to do what they call intake interviews, and they would then facilitate your pathway within the community health sector. That was the good side of the Commonwealth Rehabilitation Service. The bad side was that it was very much – each department competed against each other. So, when I went through it, if you didn't tick the right boxes in the right queues, you were challenging the system, you - - -

PROF WHITEFORD: So, sorry. Was it not having that intake – if you had have had that it would have made a difference?

MS ANDERSON: Yes. That's the fact, because when you had that intake you had a case.

PROF WHITEFORD: Right, okay.

MS ANDERSON: And that's like a profile of you, so you didn't have to – the biggest thing for me, is having to constantly readjust – every time the government changes something - - -

PROF WHITEFORD: You tell your story again and again, yes.

MS ANDERSON: - - - you have to tell your story, again and again. And my health records isn't – doesn't tell the whole – that's what I was talking about, it doesn't tell the whole picture. You need to have – that relationship is about having the ability to have people who have – you're not time poor. So that intake officer, that's what their job was, to filter you and bring you back and patch you through the process.

PROF WHITEFORD: Okay. I think that's a good summary of a key thing that would have made a difference for you.

MS ANDERSON: Yes.

PROF WHITEFORD: Okay. Any questions that - - -

PROF KING: My question: that sort of comes back to the question that I had, where you talked about privacy laws before, and access to records. Would it make a difference for you if that intake person there, and the record, that you had – that would then be the centre of your health records, and then you would have – would it help if you had access, if you had rights over then the mental health records, the medical records, that relate to you?

MS ANDERSON: In my experiences, this was the good thing and the bad thing. When you start going into private health, it's all about freedom of information, and they may or not give it to you, and they can charge anything up to \$250 to get access to it. Under the freedom of information through Centrelink, all of your reports – and that was the good thing about

Commonwealth Rehabilitation Services – all of your medical assessment reports were there, so that anyone could access it with your consent, but it was public record, technically.

PROF KING: Yes.

MS ANDERSON: Because that way, it coordinated your care even if it was documentary, but they had access to the ability. The biggest problem you've got now is that while you have the file with all the providers, they're not always accessing your files, or they're not really interested in accessing your holistic care, because it's all about the now. It's all about within the two years. It's all about the WorkCover practices, and rehabilitation processes, and if you don't quite fit in to the mould, you then fall within the cracks, which is what's happening with me.

PROF KING: Yes, okay. Thank you.

MS ABRAMSON: No, I just wanted to thank you, because you've been very articulate – no, you have. You've been very articulate about what the issues are, and a number of things that you're lived experience has shown is what a number of other witnesses have spoken to us about. So we need to really think hard about those issues, so thank you.

PROF WHITEFORD: Thank you so much.

PROF KING: Thank you so very much. Eric, is it?

MR PEREZ: Yes.

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

MR PEREZ: No worries. Eric Perez. I'm the Chief Executive Officer of the Queensland Seafood Industry Association. I do have something read in, if that's okay.

PROF KING: Please, yes.

MR PEREZ: Thank you. So, thank you for the opportunity to provide feedback to the Commission. The Association is the state commercial fishing peak body, and I'm providing feedback to you in my capacity as the CEO of that association. So, to start with, as the Commission noted on page 2 of its overview and recommendations draft report that the cost to the Australia economy of mental ill health and suicide is estimated to be somewhere between \$43 and \$51 billion with any additional \$130 billion cost with diminished health and reduced life expectancy. This isn't a good context to be talking about mental health, particularly from an industry perspective, and that's the perspective I'm bringing here. I'm not trying to diminish the experience of others, I'm only an advocate for a group of commercial fishermen, and fisher people families that are impacted by poor mental ill health.

The statistics suggest that there's no argument that poor mental ill health has social and economic impacts across Australia. Our food producers, in particular, are typically families operating micro and small businesses in coastal, regional and remote Queensland, and across

Australia for that matter, and continue to suffer for poor mental ill health. I thought I'd add 'coastal' to the regional and remote elements that are in the two draft reports that you have, because there are parts of the coast that are very much not accessible to everybody, and that's typically where we do our work.

In a recent report, and I've provided three reports to the Commission before coming here, around mental ill health led by Tania King and her colleagues. Particularly one piece of work done for the Fisheries Research and Development Corporation titled, 'Sustainable Fishing Families: Developing industry human capital through health, wellbeing, safety and resilience', provided a lot of data suggesting that there are some issues in this industry that haven't been captured before and need to be put into the public record. Now, I initially provided those three references, when I looked at the two reports I could only find fishing mentioned once in 1200 pages. But when I read the context of what was being done, I'd understood that it's not – wasn't specifically one industry or set of industry thing looked at but that tweaked this particular submission.

PROF KING: Yes.

MR PEREZ: So the work done by Dr King and her colleagues found the following, by way of summary, 'Sixty per cent of the fishers who responded to the survey had moderate to very severe bodily pain which is higher than that reported by the ABS to the general population at 46.5 per cent. Over half the respondents said pain had interfered with their normal activities. The most common health symptoms experienced by fisher's surveyed included back pain, joint pain, fatigue, stress, trouble sleeping, sunburn infections, hearing problems, over 30 per cent of those surveyed experienced these health symptoms. Surveyed fishers reported being diagnosed with a number of conditions that are high rate in the general population, particularly high blood pressure, high cholesterol, depression, type 2 diabetes and cancer.'

And finally but not less importantly, commercial fishers who responded to the survey experienced significantly high levels of high and very high psychological distress than the Australian population as a whole. Very high levels of psychological distress were experienced at 16 per cent and 16.2 per cent of fishers responded respectively compared to eight per cent as noted as high, and 3.7 very highly strained, aged 18 years and over. There's something happening in my industry that's not being talked about and needs to get some (indistinct) so hopefully these statistics will help you to do what you're doing in your work.

The report presents views of fishers themselves who identify the perpetual uncertainty generated by current Fisheries management strategies as the key contributor to their stress. Described as modern uncertainties, these kinds of stressors include closures, restructures and reform as well as the perpetual threat of livelihood loss through such management changes which are happening in Queensland as well as around the country. I'll get to the context of that in just a second.

In this State we're going through a reform process that's lasted for a couple of years now and we've had families and individuals not knowing whether they're going to have a business from one day to the next for two years which – so just ongoing psychological distress of which they've received no assistance from government, again I'll get to why that's important in a second. So from a Queensland point of view there are multiple organisations that represent

commercial fishers. There are about four that are active including the QSIA. I'm the only paid employee out of those four associations. Everyone else that does work in those bodies, including (indistinct) are all volunteers. So capacity to do anything to help is extremely limited because we are primarily volunteer organisations.

So this is what the association does at a State level, we disseminate information via social media and news posts to provide industry with information regarding mental health issues, in addition, we've recorded a podcast with various experts in the mental health area to try to get that information out. I did that off my own bat because I couldn't see that just reading an article was enough to try and get people discussing the issue of mental health, let alone dealing with it on an individual basis. Again, I claim no expertise in this area which is part of the capacity limiting parts of this industry.

From a national perspective we have an industry peak body known as Seafood Industry Australia. Its main focus has been to try to secure financial support for industry to be able to access mental health support from the government. This has involved considerable (indistinct) effort over the past few years. Both the Coalition and Labor at the Federal level went to the election with a promise of 600,000 for mental health support. At this stage SIA, Seafood Industry Australia has secured that funding and is looking to implement that across the country, 600, 000 doesn't sound like a lot of money but with an industry that's very new to trying to deal with this, it is a good start.

MS ABRAMSON: Is that restructuring money or money directly for a mental health awareness program?

MR PEREZ: Money, direct money to do that. I think, SIA is going through a process with the relevant Federal Government agencies to see what qualifies as help under that funding.

MS ABRAMSON: Yes.

MR PEREZ: So one thing that I'd like noted here and one of the things when we talk about stress and mental ill health particularly in my industry is that, it's typically coming from without not coming from within. So, I'd like to read the following into the record, 'Considerably more work and resources need to form part of industry restructure to assist individuals and families to deal with the impact of legislative or regulatory change. The current government's so-called fisheries reform, provides the Commission with an exemplar of how mental ill health is a by-product of legislative change.'

So a couple of points to note, there was no regulatory impact assessment when the reform was put in, so mental health didn't even feature in what was going to happen once these changes took effect or about to take effect. No funding that industry is aware of to help deal with the stress generated from the process, other than there are networks out there that you can access, go and access them, that's about as much as we've been given.

Fisheries Queensland Department that looks after our fisheries has provided contact details of organisations out in the ether but that's about it. And the so-called reform fundamentally change the market in which we operate for at least 24 months industry have been waiting to see its final quota allocation or how it's going to be able to catch its seafood on a year to year

basis and we still don't know what that looks like. And some draft allocations that came out, maybe six months ago, have cost some in the industry 50 per cent of their livelihood. So they're still working with an unknown as to whether or not that's the allocation they're going to get going forward. So that does nothing for better mental health.

So the question is, what is the level of responsibility that should be assigned to governments and the government agencies when changing fundamentals of how an industry operates? My industry didn't ask for this reform process. They were willing to have the conversation but now that it's in tow and things have been thrown at us as opposed to having discussions around what they mean, why should we bear the brunt of mental ill health and stress caused by that process when we didn't initiate it?

Industry did not see the government so-called reform process and again, there's a level of responsibility that Government and agencies owe industries when they do this and I just don't mean – sorry. I don't just mean this industry, I mean all food production industries, I think we're the same as the farming sector and I make note that in the first volume of the report there are groups put together so LGBTI, and young people and other groups that vulnerable to poor mental ill health.

I think in one of the categories was remote and regional – living in remote and regional areas. I think you could lump in most food production into that category because the stress being experienced by those food producers is real and it's growing and it's not a baby. Whatever the systems are out there to help these people aren't getting the job done and I'm making that observation on someone who's had that lived experience.

Finally, some key questions that arise from your draft reports for me as an advocate is, what does a fit for future better mental health strategy look like for my industry? Who should fund that strategy to implement better mental health outcomes? And are existing strategy approaches too generic or would an industry specific approach lead to better mental health outcomes for industry? And the final point would be, who pays for that? So that's my submission, so I'm happy to take some questions.

PROF KING: Thank you for that. Because you've taken us down to an individual industry, I'm now going to start off by taken it again, broader. Is it reasonable for me to say that what you're seeing with the seafood industry and I'm aware of the reforms in there because they're also happening down in Victoria and various stages I happen to have heard about them and seen the consequences on the fishing industry down there. But to what degree is it reasonable to say, what you're doing is identifying a group that we really didn't identify in the draft report which is groups industries, those whose livelihoods are undergoing change.

So it's more than just food producers, I'd put to you. I'll give the example of another group that I've worked with which is taxis and of course taxi drivers faced uberfication and we won't go into the details of what actually happened there but we do know there was literally, taxi licence owners lost hundreds of thousands of dollars and some of them unfortunately took their own lives, they saw that as the only way out.

So my question to you, do we need to think about rather than say the seafood industry or areas of Australia where food producers are undergoing stress for say, drought? Should we thinking

of how a mental health system deals with groups who are undergoing stress at a particular point of time due to changes relating to their industry and their livelihoods?

MR PEREZ: Yes, with a but.

PROF KING: Okay, yes.

MR PEREZ: Yes, I think in terms of trying to streamline services to lots of people across vast geographic area, I would agree with that. But in terms of individual level, I guess each of those individual groups have demographics that make them unique. So before you talked about its important to look at youth, mental health and suicide prevention which is a critical thing. But in my industry we have an aging fleet, so we're dealing with older, particularly older men who don't go to GP's at the best of times for their own regular health, let alone for mental health issues and not saying that GP's are the only place that they can stop there but when you don't have a culture of reaching out for mental health help, how do we bridge that gap to reach to what your – to answer your question. So I'm not anti the premise of the question, it's more, we still have to build an architecture from where we're at in our headspace to get to where the help is, and someone needs to build that bridge and (indistinct) reasons to help to do that.

PROF KING: Yes.

MR PEREZ: But if I was going to have influence on the system, is you need to reach out to groups like us and ask us what's the architecture to get from us to a system because it really just doesn't exist.

PROF KING: Yes.

MR PEREZ: Which is why people in my position and other jurisdictions in this country are hesitant to get more involved because we don't have the skills required to – we don't ever make claims that we can diagnose.

PROF KING: No - - -

MS ABRAMSON: Mr Perez, could I ask you something. Sorry, to interrupt, Stephen.

PROF KING: No, please.

MS ABRAMSON: But there have been initiatives in things like construction, you know, Mates in Construction and I'm just wondering with your industry association whether there would be learning from those types of organisations, which are grassroots organisations, so appreciate there's been a CFMEU involvement in that, whether you'd see a space to do something like that given what you've just talked about.

MR PEREZ: If it's not reinventing the wheel, they can help, yes. We'd be happy to look into that. So for us, we're an open book when it comes to what can we do to help because one thing that I've seen in the draft reports and in the topic more generally, and please correct me if I'm wrong, again I claim no expertise here is that research around why mental health is important, I think that needs to stop. We need to be worried about intervention, how do you help people

getting over the humps in their life, whatever that might look and from an industry advocates perspective, I'm talking operators that are still capable of going to work and (indistinct) a living. I'm not talking about those that have profound mental ill health that need medical intervention. So that spectrum it's a massive - - -

MS ABRAMSON: Well I understand that. The reason I raised the Mates in Construction is because everyone working in the industry could see the very high suicide levels amongst a predominantly male workforce in construction, a tough environment, where talking about things was not the norm. But I think, and I could be corrected on this, the evidence is that they've really made quite a lot of inroads into the culture and people being able to talk about mental health issues. So I'm just putting that on the table.

The other thing too is, I am aware in a number of restructure – industry restructures which Commissioner King talked about, that I think, I could be wrong here, but I think with some of the farming support that actually put some mental health supports in as well. So we understand what you've said to us about an industry which is restructuring but I would ask you to have a look at the Mates in Construction, because I think you'll find that they would be very helpful and willing to talk to you.

MR PEREZ: Yes.

PROF KING: And Mates in Mining is another one, it's done the same sort of thing.

MS ABRAMSON: Yes.

PROF KING: Yes.

MR PEREZ: So that was Mates in Mining.

PROF KING: Mates in Mining, yes.

MS ABRAMSON: Mates in Mining and Mates in Construction. It doesn't take away from the evidence you presented to us but they are programs with very similar workforces.

MR PEREZ: Yes, yes.

MS ABRAMSON: Could I ask you one additional question. I've made an assumption about the workforce but are your members basically family run businesses?

MR PEREZ: Micro and small, yes.

MS ABRAMSON: Yes.

MR PEREZ: So multi-generational - - -

MS ABRAMSON: Yes.

MR PEREZ: - - - families and one thing I didn't put in the notes but for the record, a lot of the small scale fisheries, so your small crab fishing businesses and net fishing businesses which catch the majority of the fish that people consume are very much regionally based. So where they live is where they work and there's a difficulty when you have reform processes, again, not that we call for them but they get thrust upon you that because you've got flexibility in your licence to fish somewhere else, the assumption is from those that have never actually done the job that we just blank out this bit of coast line and you can just go somewhere else. Try doing that in your job, how about we stop you getting your pay for six months and you find somewhere else, to work somewhere else geographically which is never taken into consideration yet these are the people that set up the structures in which we work in. So, yes.

MS ABRAMSON: We were quite - - -

PROF KING: Sorry, just to follow up on that because I just want to make sure I'm not assuming stuff about the industry structure. So, it would be situation where the fishers would be licensed, their licence would usually be for a particular catch, as in the quantity, what they're allowed to catch and the geographic location, where they're allowed to do that catch?

MR PEREZ: Yes.

PROF KING: Yes. Okay, because that's the Victorian situation and I suddenly thought I better check and I'm not assuming stuff that's incorrect.

MR PEREZ: It's pretty similar around the country except with what we're going through now under the change process, there will be more what they call, 'Fishing zones', so you can only fish in a certain zone and not the whole coast which then limits your ability to move from one region to the next and that's what was built into the flexibility of these businesses before the change. So that's why there's people, you know, 24 months in they still don't know, well what is my business structure going to look like until they tell me what my allocation is - - -

PROF KING: I think in Victoria it's been zoned for quite a while.

MR PEREZ: Yes, slightly different. Yes.

PROF KING: Sorry, I just jumped in.

MS ABRAMSON: Sorry, I just wanted to ask one final question if I may and we would welcome a submission, it's about access to services because I'm also making an assumption that your members work very irregular hours. So the fact that they would be able to access what we might call mainstream services might be very difficult. You've talked about them being in coastal regions. So having something said to us directly about that would be quite useful. Thank you.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you.

PROF KING: Yes, is Kay Cogan?

MS COGAN: Yes.

MS ABRAMSON: You'd like that Kay is a formal submission?

PROF KING: Yes, fantastic.

MS ABRAMSON: Yes.

PROF KING: Thank you.

MS ABRAMSON: Thank you, very much.

PROF KING: And if you could state your name, if you're representing an organisation, the organisation and any opening comments you'd like to make?

MS COGAN: Okay, thanks. Kay Cogan is my name. I'm a teacher and I'm representing a group. There are three elements to the group. A group of psychiatrists on one side, me in the middle and an IT group on the other side. So I want to address the key point of early intervention which I think is seriously serious, right.

I've worked in early intervention in the early childhood field, I've worked at all four levels of education but my main focus is early childhood education. And I've (indistinct) early childhood centres across, Brisbane, London, Dublin and Shanghai. So I'm very committed to the concept of early intervention because I've seen it work, right.

We've all moved as a society to child-minding to appreciating the value of early learning. So I think the report, the key point in the report about early intervention really is vital. I too have lived experience of mental ill health. Four of my immediate family (indistinct words). Now we understand that they were undiagnosed bipolar and at high risk of suicide. We didn't know that at the time and several, including me, have been diagnosed, you know, in our sixties but it's brilliant that we have been. Well, there have been no more (indistinct).

So with this group of people it's all pro bono. This is not a, you know, an employed group and these psychiatrists are from Brisbane, the Gold Coast, UK and Ireland and we all communicate. And we looked at the idea of 'one stop shops'. You know, this is going back years. We were toing and froing for quite a few years. We looked at one stop shops which I suppose would be the headspace model now and my experience of child care centres said, you know, 'Forget it. The capped costs will be ridiculous and it will be totally expensive' so we kind of went into a shallow period after that and did nothing.

And then somebody came along and said, 'How's this thing going?' and I said, 'Oh, not very well' and he said, 'Have you thought of digital?' and I said, 'No'. So we all got together with this company called 'Crowmorf' down in the valley near the precinct and they have - they specialise in education. Their latest is for the - whoever does the driving test, (indistinct words), they put together a digital program where kids no longer have to read out of the book, we all had to learn the (indistinct words), they do it all online and it's just phenomenal, it's brilliant and now, you know, it's going from Brisbane, it's going to the Northern Territory, to Tasmania,

to all sorts of places.

So we all sat down and thought, 'would this work?' and the answer is 'Absolutely'. So the psychiatrist obviously - I mean, it's a bit like a butterfly (indistinct words). Psychiatrists offered the, you know, the deep information, the expertise, the science, all of that. I'm in the middle and I do what I did for the Office of Child Care 40 years ago. I take that and as a teacher I can stage that information on every topic, right, so whatever topic is in I bring it from age of three, do do do do do, up to 25 and going back to early childhood there was a huge emphasis on parental education as well so we can do all of that so you're doing a parent education program, or call it what you will, in line with students. So your tackling the vulnerable group from age three to 25. The beauty of it all is to build the platform we (indistinct) 1.5m, that's it. Now, that can go nationally. Everything is fragmented at the moment. You know, there's a scattergun approach, this could be an absolutely national program.

Now, our experience has been a - disappointing is a mild form of it. For instance, we saw where the prime minister announced that he was going to - I think he was going to eliminate suicide or he was going to (indistinct words- anyway, and he appointed a woman, Christine Morgan I think, as the head of that. So we made an appointment, a group of us, to go off for the day, made an appointment to go down to Sydney and talk with her and unfortunately on the day she was called to Canberra so we talked to somebody else and we were blown away to learn - now, Christine Morgan had been quoted as saying that she was looking at an upstream national program and we thought, 'We have it, now it's done' so we were told that, 'No, no, no, there is an expert group being put together and at the end of year two a report would be expected' and we went, 'Oh, God Almighty', you know, like bang your head against a stone wall but I suppose the reason I'm here today is to say it's there, the expertise is there, the goodwill is there, because, you know, we've kind of stayed together for maybe - five/six years this is backwards and forwards - and the Eureka moment was go digital. So that's all I've got to say.

PROF KING: So at the moment - so the concept is there but it's that 1.5 m that is need for the platform.

MS COGAN: That's needed to be the platform, yes.

PROF KING: Yes, okay. The elements that you've got going into the platform, the issue whenever you're going after government funding is going to be, 'Ah, well you need the evidence of the efficacy of bits that you're putting together in the program so that it can - you know, where are the evaluations? Where is the evidence that this is actually going to work?'

MS COGAN: I've never gone after government funding before so this is news to me, all right.

PROF KING: No, no, right.

MS COGAN: I suppose the evidence - I mean, you guys are the experts. Can you say that early intervention works or are you simply recommending it and then evaluating it?

PROF KING: So we may know early intervention works, the question is though the specific platform that you're putting together - so you're putting together a digital platform which will

involve programs, information and so on going from 3 to 25 so the question that will immediately come, and I'll ask the question, is 'Where is the evidence that what you have chosen to put on your platform is the right stuff?'

MS COGAN: Right. Well, there is no proof until it's done but what I can say to you is that as an educator, and this is an education program, right, and the people providing the information are psychiatrists with the knowledge, it's like giving the, you know, Macbeth, 'I didn't rape Macbeth' but I damn well know how to teach it.

PROF KING: Yes.

MS COGAN: That's where - and also the method of teaching it through digital is aligned with, you know, Mission Australia say that this particular group really, really, really want to access stuff online. They don't want to be face to face.

PROF KING: Yes.

MS COGAN: I can tell you that I've had great success with the early learning framework and curriculum but I didn't invent it, you know, it came from the research in '74, it came from HighScope in Michigan University and Serco in UQ brought that into Australia. I took that research, right, that wasn't my stuff but I knew how to put it into a framework because I knew the stages of development, I mean, every teach does.

PROF KING: Yes.

MS COGAN: And I was then able to build that up to a curriculum and, you know, that's still working today so all I can say is I believe in us.

PROF KING: That's good.

MS COGAN: Yes, that's it.

MS ABRAMSON: No, I'm fine, thank you.

PROF KING: Thank you very much for that.

MS ABRAMSON: Thank you very much.

MS COGAN: Thank you.

PROF KING: We will take afternoon tea and let's reconvene at 3.20.

SHORT ADJOURNMENT

RESUMED

PROF KING: Now, I should ask Irish, Scottish?

MS CLELLAND: Scottish, yes.

PROF KING: Scottish, all right.

MS CLELLAND: West of Scotland, so we don't pronounce our words as well as the east coast. So good luck with your transcript technology.

PROF KING: Okay. Good to go again. All right. Sorry, if you could start again, Irene.

MS CLELLAND: It's okay. So my name is Irene Clelland, I'm the CEO of Arafmi, Queensland. So I'm here to represent them today, and we're working with Mental Health Carers Australia under their broader umbrella and the recommendations. On a personal level I have a lived experience of mental illness and was a survivor of suicide in my teenage years. So have that personal connection to the mental health space also. Are you happy for me just to - - -

PROF KING: Please, yes.

MS CLELLAND: So thank you for letting us speak today. I've got eight very small points to raise and again they've come - I believe Mental Health Carers Australia have been represented at each of the public hearings already. So I'll just - I'll go over them briefly and welcome any talking points or comments.

PROF KING: Okay.

MS CLELLAND: So first of all we thank the report for mentioning families and carers, but we feel that the report and the recommendations doesn't necessarily reflect families and carers of people who are mentally unwell on a - on the more ongoing recommendations area. So we would welcome some additional work in that space to make sure that they're included. We would also like to push a greater emphasis on relational based approach to recovery, and I'm happy to talk on that a little bit later on. I believe that's been something that's already been discussed at length. We would welcome a shift to inclusive practice and we would encourage mandatory recommendation for the practical guide for working with carers of people with mental illness in any systematic change, and again I'm happy to talk on the practical guide in detail if you like.

We would also welcome a relationship approach to co-design. So whatever new system comes into play to have a co-design process that includes family and carers in the actual design element. And a couple of positives that are not for (indistinct), we fully endorse Mental Health Australia's Time to Fix Mental Health campaign, and we support the Productivity Commission's findings on the recommendations in relation to carer income support and those recommendations and changes. So thank you for that. So that's the very, very brief talking points from Arafmi. I'm happy to clarify any of those if you need.

PROF KING: Okay.

PROF WHITEFORD: Can you just run us through those - you mentioned in relation to recovery and co-design, there was a third one.

MS CLELLAND: The practical guide for working with carers - - -

PROF WHITEFORD: Yes, that's right.

MS CLELLAND: - - - of people with a mental illness.

PROF WHITEFORD: There we go, yes. I think we were both focusing - can you run through just a bit more on what you're after there or what - - -

MS CLELLAND: Sure. So the practical guide for working with carers of people with mental illness in particular, so really it does what it says on the tin, it is a very practical nice easy to understand guide of how to include families and carers in a person's journey through service provision, and how carers can be included in that space and there's been prior comments about how do we navigate consent when somebody becomes unwell and carers or families are engaged in that space. Obviously consent is really important from the individual prospective but the guide gives some really nice gentle recommendations about how to open up conversations around inclusion and consent so it's not a: do you want your mum and dad to know, yes or no, it's about who's involved in your life and who's a support outside of a clinical setting.

When you're working through your recovery, who are the people that are in your life that can provide support and help. So it's a really practical guide to help people who might not always engage with family and carers in that space.

MS ABRAMSON: Ms Clelland, we've received some evidence and I'm really interested in your view, that we had thought that - a lot of evidence was presented to us from carers saying we couldn't help our loved one because of the consent and all of those issues. But we also had evidence that in the right circumstances, with a skilled health professional, it was actually quite rare that somebody didn't want a care person to have the information.

MS CLELLAND: Yes, that's correct.

MS ABRAMSON: Is that your experience? Yes.

MS CLELLAND: Yes, that's completely our understanding of it, and sometimes the - it's the approach to the conversation that's - - -

MS ABRAMSON: Yes.

MS CLELLAND: - - - the lynchpin between a person being involved and a person not being involved. Arafmi Queensland provides support to over 300 carers in Queensland and the majority of those carers are involved in their loved ones support and recovery and generally part of their ongoing staying healthy and well part of the recovery. So - and when they're included we get better outcomes. But, yes, generally people find that if the right questions are asked and the right support is there that that happens. But I was speaking to a carer just today

round their engagement with their loved one's - their loved one is unwell at the moment and being able to access some connections with their clinical supports has not necessarily been the most positive, and I think that's largely around the - either the lack of education or training from the clinical perspective in that engagement space and how we work together with carers, even if they're presenting as wanting the gold star service.

I heard a comment a few weeks ago from a service provider saying the problem with carers is they always want the gold star service, and I think well none of us wake up in the morning and go "I would just like a substandard day please" or "I'd like something to just be average", of course, we want the best for ourselves and our loved ones and sometimes in periods of stress we might not necessarily articulate that in the most positive way but I think it's the responsibility of services to engage and understand that where the carer or the family member is coming from, that we can try and translate that in a different way.

MS ABRAMSON: You've got to say it's a really interesting issue because we had been thinking about it from a legal prospective of (indistinct) care directives but over the last few days and certainly your evidence has sort of led me to believe well actually a part of this is the skilling and uptraining of busy staff - - -

MS CLELLAND: Absolutely, yes. Yes.

MS ABRAMSON: - - - that actually they can have that conversation.

MS CLELLAND: Yes, and I think that the practical guide works really well for just helping people understand even just those opening questions to the person who's experiencing service delivery or experiencing clinical care, that we can ask those questions slightly differently from yes no answers or be ready come back that if the person is not responsive to engaging in that conversation that we come back at a time where they're ready. Now, obviously if people still don't want to consent it's not about pushing through the carer's agenda, it's about having a bigger picture of who's involved in the person's life, and ultimately people get better outcomes when they're connected with their loved ones and their community of choice.

MS ABRAMSON: Do you still see a role though for some legal documents when a person is quite well signing in advance (indistinct) - - -

MS CLELLAND: Yes.

MS ABRAMSON: Yes.

MS CLELLAND: Absolutely, and that can be from who you want to engage - - -

MS ABRAMSON: Yes.

MS CLELLAND: - - - to how you wish to receive your services. I think there's some really good opportunities for more choice and control in people's care, like do you even attend a hospital, do you want to go a peer connected space instead of a clinical setting. All of those kind of things are really important in advanced care directives and who you include in that.

MS ABRAMSON: Thank you.

PROF KING: So just on the advance care directive, one of the feedbacks we've had is well they're all fine but we get them in other parts of the health system already but clinicians don't pay any attention to them.

MS CLELLAND: Yes.

PROF KING: So any thoughts about what's needed?

MS CLELLAND: I didn't write this document, but I'd go back to the practical guide for working with carers - - -

PROF KING: Yes, okay.

MS CLELLAND: - - - that I think if people have a - or services have a different understanding about the role, and we talk about family of choice so it doesn't need to be blood relatives - - -

PROF KING: Yes.

MS CLELLAND: - - - it's whoever cares for the person and provides support for a happy, healthy life. That if people understand the positivity of those connections they might be asking slightly different questions and that includes clinicians. I've delivered training for clinicians previously on mental health first aid and clinicians are not immune to having mental health issues themselves, in fact it's an incredibly stressful job and having them understand that the - that everybody can be touched by poor mental health or by mental illness and how we just engage and connect with each other a little bit differently. I don't see that clinicians are exempt from that, but the practical guide just gives some really nice gentle ways of helping people engage differently, and it doesn't take too much time.

It can take a couple of minutes conversation or the shift of your language slightly to reflect on how you might do something differently or how you might engage in a conversation differently. It can take 30 seconds.

PROF KING: Okay. Well, thank you for that. Harvey, is there anything?

PROF WHITEFORD: No, no, I think that's good.

MS ABRAMSON: I had just one additional question. We've had a distinction made today, which I'll be honest I hadn't quite appreciated, which was between peer support and peer workforce. So I'm really interested in your - I mean it's obvious when you think about it, but it's not how I've been thinking about it. So I'm interested in your views.

MS CLELLAND: Yes. I think they're both equally valuable. My personal view coming from a perspective of having a lived experience of mental illness and being through some challenging times, particularly in my teens, it's very helpful from a peer perspective to understand that people can and do recovery from mental illness and can flourish in whatever capacity of life they have. I think from a peer workforce perspective it's important that there's a framework

around it that's intentional and it's how you want to work with people. So it's not just people going well it's my idea of what recovery is, therefore - - -

MS ABRAMSON: Yes.

MS CLELLAND: - - - I'm going to give that to you. But peer support can be that. Peer support in a very informal way is whoever has an experience, and I think from a workforce perspective there should be a framework around that, and I would include carers in that too. I think about when I came out of hospital in my mid-teens and my mum and dad thought that they were the only ones who'd ever experienced this, and does this mean that my daughter's going to be unwell for the rest of her life? And having connections with other carers who've been through that experience might have helped reassure them that I was going to be okay or that they needed some support for themselves to give them a bit of break. So I think the carer aspect of having peer support is incredibly important too. So I think there's a space for both of them. Do you want a definition of the difference or you're happy (indistinct words)?

MS ABRAMSON: No, no, it's very - no, it's very helpful, and the other thing too was carer support was an interesting - the number of comments that were made to us, because after all when you look at what's done for children with cancer that's actually one of the biggest things that - - -

MS CLELLAND: Yes.

MS ABRAMSON: - - - the support organisations do is support for the families, so I'd appreciate - - -

MS CLELLAND: Yes. Yes, and I think just even from a fiscal perspective the \$13 billion that carers provide - - -

PROF KING: Yes.

MS CLELLAND: - - - and those supports, it's absolutely invaluable. It would be nice if the - we would do it differently so that they don't necessarily need to provide those supports, that they can engage in just loving relationships with their family members, but I appreciate that that's a really complicated system that you're not here to resolve with the Productivity Commission, but it can be a wish for the future.

PROF KING: Actually just on that - sorry, Julie, did you have - - -

MS ABRAMSON: No, no.

PROF KING: Yes, so just on that because actually the idea of a carer peer support is really nice, I like that. But the other bit that we've sort of touched on in a couple of hearings, the issue of young people who are also carers.

MS CLELLAND: Yes.

PROF KING: Any thoughts on how do we support those young people? How can we improve things for those young people to make sure that they're supported in their education and so on?

MS CLELLAND: Yes. I think the first thing is recognition that young carers do actually exist, and that they do need support. Having more education and awareness of where young people engage, which might be schools but it might not be necessarily. We've got some representatives from headspace here today. So places where young people might actually engage. Having the people that they engage with having the awareness that young carers exist and that there's supports and provisions available. Arafmi provide a young carers support group so it's a peer support group which helps people around understand the role of young carers working with each other as peers to develop strength and skills outside of their caring role

There could be more information in the education system, but even things like sports clubs, anywhere where young people engage, having that awareness that young people do go through that space as well. I think young carers are not necessarily talked about as much. Arafmi conducted research recently and the predominant amount of people who responded to the research were women who were 50 plus. Our first thought was does that mean that all carers are women who are 50 plus. Well it's not, it's the people that we were getting the message out to that we wanted information from. So we missed a whole cohort of young people that might have been able to give us a different story about what their needs and wants are. But I certainly think it's worth more investigation.

PROF KING: Okay.

MS CLELLAND: I probably haven't quite answered your question properly on that - - -

PROF KING: No, no - - -

MS CLELLAND: - - - apart from I think there's not enough recognition of young carers and their actual existence.

PROF KING: Yes.

MS ABRAMSON: Is that because young carers don't identify as carers because they're just "mum's always been that way, I'll just look after the family".

MS CLELLAND: Yes or they haven't developed the skills yet how to articulate it.

MS ABRAMSON: Yes.

MS CLELLAND: So they might communicate through absence at school. They might communicate through their behaviour in a particular way, and might not necessarily say, well "I couldn't eat this week because mum wasn't well" et cetera. So helping young people develop those skills of communication so that they can actually ask for help or tell us what they're going through is another area of support.

MS ABRAMSON: That's been really helpful. Thank you.

PROF KING: Thank you very much.

MS CLELLAND: No worries. Thank you very much.

PROF WHITEFORD: Thank you.

MS CLELLAND: How was the transcript with my voice? Was it okay?

PROF KING: Okay. Dr McLaren, would you be happy to go on now? Sorry, you walked in and we're dragging you up immediately. We're being very productive and getting ahead of schedule.

DR McLAREN: That's very good. Which is how it should be.

PROF KING: So if you'd be able to state your name, if you're representing an organisation, what the organisation is, or otherwise your capacity for appearing here, and any opening comments that you'd like to make.

DR McLAREN: Sorry, I'm - - -

PROF KING: No, no. Take your time.

DR McLAREN: First comment is I've, with all the smoke, my chest is not real flash at the moment. I'm coughing and spluttering a bit.

PROF KING: I can sympathise. I get the same sort of reactions to smoke, but fortunately haven't had it this time.

DR McLAREN: I'll find my glasses. Yes, my name's Niall McLaren. I'm a psychiatrist and I'm in private practice - sorry, a bulk-billing private practice in Brisbane, and I've got extensive experience in remote areas, including six years in the Kimberley. 1987, Veterans Affairs Aboriginal (indistinct) et cetera, et cetera. And I put a submission in which is No.44, which was fairly long, I'm afraid, but it just kept growing, and I just want to comment on the draft overview. I haven't read the full draft itself, but the overview.

So the overview crams a lot into a small package. There are many recommendations, most of which aren't contentious, but they won't come cheap. And for example, you're specialist teachers in every school is about a million a year. And that item is part of a very large proposed expansion of bureaucratic regulatory and research machinery going in the institutional mental health practice. This is not surprising, of course. If you ask a group of bureaucrats (indistinct) or epidemiologist for their advice, your answers will automatically orient in a particular direction.

Now, the only surprise lies in the fact that they're suggesting something that we already know won't work. 15 years ago in a review entitled 'Do nations' mental health policies programs and legislation influence their suicide rates?', an epidemiological study of 100 countries. The authors concluded it is of concern that most mental initiatives are associated with an increase in suicide rates. Now, I don't know why they were so concerned, as this was actually first

shown in the 1960s after mental health services were introduced into the Baltic island of Bornholm, and everything got worse.

So in 2014, there was an exhaustive Danish study showed - of which - what an editorial by two Australian psychiatrists called, 'The disturbing possibility that psychiatric care might, at least in part, cause suicide.' It emerged from that very detailed and reliable study that contact with mental health services didn't cure suicidal urges, but very often seemed to make them worse. Now, the editors, Matthew Large and Christopher Ryan, and I don't know - appeared shocked by the thought that the trauma and stigma of being hospitalised - that was their term - may push people over the edge.

That a visit to the local emergency department was suicidogenic, as they put it. But they shouldn't have been shocked. You only have to talk to patients to find out what they thought of their 'hospital experience', and overwhelmingly, it isn't nice. It seems that the more we spend on mental health, the more prescribed drugs people, the more ECT we give, the worse the outcomes. Now that paper, whose authors included Professor Whiteford, asked whether there may be acceptable reasons for these observed findings.

This tends to be the response of the great majority of psychiatrists who only want to hear answers acceptable to themselves. As the late Carl Sagan noted - and most of you probably know, he was an astronomer of considerable renown - he said, 'At the heart of science is an essential balance between two seemingly contradictory attitudes. An openness to new ideas, no matter how bizarre or counterintuitive, and the most ruthlessly sceptical scrutiny of all idea, old and new. This is how deep truths are winnowed from deep nonsense.'

Now I submit that the reason massive expansions of the bureaucratic regulatory and research machinery don't achieve what they're supposed to is because the entire model on which it's based is not just broken, but in fact it doesn't exist. All the recommendations listed in the overview won't change this, because psychiatry itself is riven by deep nonsense. Let's take the recommendation that children should be screened for signs of mental disturbance. Will the psychologist tell the parents, your little Johnny's playing up at kindy because of all the arguing at home. He's only copying what he sees.

Or will they say, your little Emma is seriously anxious because her father yells and punches walls while her mother is out doctor shopping for drugs. Now that won't happen. What will happen is that the parents will be told, Johnny has ADHD and needs to be on drugs for life, or Emma has ASD and social phobia and needs to be on drugs for life, and they won't get better. So let's look at my particular bent (indistinct) ECT; electroconvulsive therapy.

Now, I provided all the figures in my critical review of ECT which was published last year, and I appended that to my submission. If you want a copy of the paper, it's actually on the website. So from 2005 to 2015, private ECT in Australia increased by 87 per cent, including an implausible 191 per cent in Western Australia. In the UK, from 1985 to 2015, ECT usage went down by 90 per cent. In my 42 years as a psychiatrist, including 25 years in the far north, the rough end of psychiatry, I've personally - personally assessed and managed somewhere from 12 to 15,000 unselected public patients.

And today, I run a bulk-billing practice in Redbank Plains, and another one in Kenmore. I get

about 300 new referrals a year. I just picked up my appointment lists for last Wednesday and yesterday, so that's what I do. There's three new cases in there that are an hour each. There's four new cases yesterday for an hour each. So that's pretty busy. I run this bulk-billing practice. Now these are patients who will otherwise go to mental health services, if they got any treatment at all.

So in 42 years, not one of my patients has ever received ECT. Not one. That includes six years as head of department of Veterans Affairs in Perth, and three years as head of department in Darwin. If I can practice public psychiatry in Perth, in the Kimberley, in Darwin, and in Brisbane, without ECT, so can every other psychiatrist in the country. Now, according to the RANZCP, that's the College of Psychiatrists, 'ECT is an essential' - that's their word - 'treatment for severe, life threatening depression.'

If that's the case, can they explain why the overwhelming bulk of ECT in this country, including almost all of that recent increase, is given to distressed, middle-aged, middle-class, white women in private hospitals. The answer, of course, is money. The psychiatrist gets about \$200 for pressing an electrode against an anaesthetised patient's head, which is about, you know, two minutes work at the most.

Of these new cases yesterday, I get \$225 for the new case. That's an hour, plus all the extra work writing the report. One of them yesterday was a 47-year-old veteran with a wrecked back, whose wife had left him, and he's in a terrible state. He was aggressive. He hates psychiatrists. He hates everything, and I had to work for my money. I didn't get that just for, you know, going buzz, there you are dear, you'll be right. I wouldn't have said 'there you are dear' to him, that's for sure.

So naturally psychiatrists like ECT. Why wouldn't they? An admission to hospital for 12 ECT costs something of the order of \$57,000. So private hospitals profit handsomely. ECT in Australia is a \$500m a year industry, yet my figures established that not one of - not any of it is medically necessary. As it happens, I get the same results as they do in the same or less time for under \$1,000. You can look at all the results in that ECT summary that I commend.

Harold Sackeim of New York, who is one of the leading exponents of ECT in the world, says that only about 60 per cent of his patients will respond to ECT, and almost all - that's his words - almost all will have relapsed within six months. Well, I can do a hell of a lot better than that for under \$1,000, which is a 98 per cent saving. I am utterly unconvinced that ECT is not essential, safe, necessary, or effective.

Over many years, psychiatrists have shown themselves unable to self-supervise in this area, and it should therefore be banned. A massive saving to the community. There is not one shred of evidence to say that mentally troubled Australians would be worse off if - but the Commission will not hear this from mainstream psychiatry. The same goes for the suggestion that the 'emergency department experience' should somehow be made less awful, and that's completely wrong.

The only way to prevent the suicidogenic stigma and trauma - so that goes back to Ryan and Large, was it, I think. That's their words. The suicidogenic stigma and trauma of going to hospital is to provide accessible local services. Of my 300 new cases a year, practically none

will be admitted to hospital. They don't take overdoses. If service is locally available in a pleasant setting, if people don't have to wait; so all of those patients will be seen within two minutes of their allocated time. They do not wait. Not like public hospitals where you wait eight hours.

If they see the same person each time, if they're not brutally forced to take unpleasant and/or dangerous drugs, if they're not treated as cattle, then people will happily stay away from hospitals. Problem solved. So I've got a bill here from Princess Alexandra Hospital for a person who got charged for ineligible emergency fee, category three, 17 May 2019, Princess Alexandra Hospital, one visits, \$838.35. Oh boy, just give me \$800 for each person I keep out of public hospital. I'd be very happy.

So nobody wants to go to hospital, so the way - if you provide alternative, they won't go. The problem is that mainstream psychiatry controls the narrative of mental health, and I use that word in the very worst, postmodernist sense. Results like mine, spruiking mainstream psychiatry's narrative, that they know all about mental disorder, and it only needs a few tweaks and a flood of money to make it all come together. This is false.

Mainstream psychiatry does not have a (indistinct) disorder. Therefore their treatment is a hotchpotch of serendipity, ideology, and blind poking. However, they routinely mislead the general public in this manner. For example, the claim last year by the RANZCP, to quote, 'The prescription of medications is something that a psychiatrist only ever does in partnership with the patient, and after due consideration of the risks and benefits.', unquote.

So I immediately lodged a complaint with the College and said, that's completely false. Every day, in a 100 centres around this country, tens - sorry, thousands of people are held down and injected against their will without a single word of explanation of what it is. So I said to the College, that's a falsehood. But they dismissed the complaint. So I lodged a complaint saying that they'd not followed their complaints procedure. The current president, director of mental health here, dismissed that complaint too.

So it went to AHPRA, who dismissed it in 24 hours, and I lodged an appeal. That was dismissed after a month. So it went to something called the National Ombudsman for Privacy and Health, or something that I'd never heard of, and they said, no, no, no, that's okay. You can lie to the public. So I did a little study which showed that of 100 consecutive patients, 75 per cent of my new referrals were already taking psychiatric drugs when they walked through the door. Half from GPs, half from psychiatrists.

Not one had been given anything like adequate information. So what the College of Psychiatrists said last year is a flat, in your face, lie. And they don't care, and AHPRA doesn't care. All right, and that's (indistinct) do. They control the narrative. So ECT, I submit, is part of the deeply entrenched, institutionally sanctioned, soft corruption of over-servicing. I note somebody else has commented on this at submission No.513, and I urge the Commission to study that one in detail, and impartially.

But it's not just in the private sector. I remind you that it costs Queensland - according to those figures I put in - it costs Queensland Mental Health Services four times as much for their junior staff to see an outpatient as Medicare pays me. Four times as much, and their results are not

really good. And they're exactly the same patients. I mean, I know. I worked at the Goodna Mental Health Services outpatient clinic when I first came to Brisbane. I thought it would be a nice way to get to know people, and I know exactly what they get.

And they people walk from there up to my place saying, I'm not going back to there. I'm just up the road from Goodna outpatients. It costs them four times as much. The only figure I've seen for their inpatients also come from Princess Alexandra. Same patient. A day in their mental health services ward, \$2,237.65. So every time I keep a patient out of hospital, it's a massive saving to the community. I don't believe that that's - can be justified. Okay.

So more of the same, as suggested in this Inquiry's draft report, will not achieve anything except create lots of jobs for bureaucrats, lawyers, and epidemiologists. All too often, more means worse. Down at ground level, where I practice, nothing will change. I can tell you now. Nothing will change. At \$65m a year, you can believe me when I tell you that Beyond Blue has zero effect in Redbank Plains. None.

At \$11m a year, Queensland Mental Health Review Tribunal has not led to any measurable improvement in practice. None. And more likely it's made it worse, because the medical officers now spend most of their time writing submissions, or cutting and pasting submissions to the Mental Health Review Tribunal. I know, because I've had to supervise them. I was appalled. And so what about headspace? Well, you can forget that. That's a complete non-event, and \$350m of new money isn't going to change that.

What about digital files? Well, ladies and gentlemen, if this report from Royal Brisbane Hospital is any indication, it's not going to be any different. This material here is the patient's assessment, life history, medical management, formulation, the lot. That's it. That's all there is. The rest of this is - that's it. That page is completely empty. Next page, it's got two or three ticks in boxes. That's it. And the next page, nothing, and the last page, nothing. GIGO. Garbage in, garbage out.

All right. So I grabbed a couple of my files just to show you. So this is a 42-year-old man with a very complex medical and psychiatric history on an invalid pension. I saw him one day. That's the letter to his GP that went the next day. All right. That's it. The next day, the GP had that on - on the thing. This is a man with plenty of experience of mental health services. This is a more complicated case; this is a Veterans Affairs case.

PROF KING: Sorry. Just because it's on the transcript, if you could describe. So, for example, the letter to the GP was approximately two pages in length.

DR McLAREN: Okay. Well, that one, the letter to the GP was one and half densely typed pages. This one to the Veterans Affairs is three and half pages, all set out, everything. That was on the medical officer's desk at 7 am the day after I saw him. If you put that into the system, it will work. If you put this stuff from Royal Brisbane Hospital into the system, you might as well just stop wasting your time, because nothing - no good will come of it.

Now, as I said, GIGO. Garbage in, garbage out. All this money would be better spent on public housing, just because the real problem in psychiatry lies much deeper than these solutions can reach. Now, it's reached the point - I'm just about finished, sir.

PROF KING: No, that's fine.

DR McLAREN: Reached the point where psychiatrists routinely attack anybody who has the temerity to criticise their entrenched view. For example, the UN Human Rights Commission special rapporteur on mental health has issued two reports critical of mainstream psychiatry's reliance on drugs and regulatory systems. For this, he's been subject to a barrage of ill-mannered and factually wrong criticism, often from Australian psychiatrists. When psychiatrists are so insecure that they need to assail the UN Human Rights Commission, we know there's something wrong.

There is indeed something rotten in the state of modern psychiatry, and it is the artfully concealed absence of a formal, articulated model of mental disorder. When medical students vote with their feet in not choosing psychiatry as a career, they are showing that they're at least intuitively aware of this. All the money in the world, all the committees, the research projects, aren't going to do any more than rearrange the deck chairs, because deep nonsense has now taken control.

And I'd just say that no doubt, for talking about this, I'll get yet another complaint, which will be an anonymous - from an anonymous complainant, secret, held in - heard in camera by an unnamed committee, using evidence that I can't see, making decisions that I can't appeal, but that's the way it goes. Thank you, sir.

PROF KING: No, thank you. If I can start off, just by asking you a few questions, and yes, thank you. On the early screening one, the media reaction immediately after our reports means that we have to make it very clear that what we're talking about is exactly the thing that you said, that there needs to be family support brought in, not medication of the child.

DR McLAREN: Yes.

PROF KING: And that's actually what we mean by the early screening.

DR McLAREN: Okay.

PROF KING: So, when you say, 'Will there be someone saying, "Well, dad's hitting the wall when mum's out of the house."' Maybe not that, but there needs to be the support so that if that's occurring in the house, that becomes relevant.

DR McLAREN: Sure, sure. But if the quality of the screening is as good as Royal Brisbane Hospital puts out, then you might as well save your money.

PROF KING: Yes.

DR McLAREN: That's hopeless. This is disgraceful.

PROF KING: Yes.

DR McLAREN: That's all there is to it. The premier hospital in the state, and it functioning at the level of disgrace. If a medical student did that, I would fail him. It's simple.

PROF KING: Can I ask on – so, you talked about hospitals and ED. Your view on ED diversion? So, which is what we talk about. So, are you familiar with things like the safe haven cafe model? So, somebody who's feeling distressed, it's 2 am, rather than going along to ED, they go to a cafe where there's peer – they can have a cup of coffee, and talk with relevant peer workers, or peer volunteers?

DR McLAREN: Yes.

PROF KING: So that's an – your view on something like that?

DR McLAREN: Well, I operate Emergency Department Diversion very successfully, and I have done so for many, many years.

PROF KING: Yes.

DR McLAREN: I did so in the Kimberly. The reason I went to the Kimberly was to stop Aboriginal people being referred to Perth. My first year, the number of year sent down to Perth dropped from 52 to 2. That was a saving of a quarter of a million dollars, just in airfares alone, not the cost of hospitalisation, and my salary at the time was \$100,000. So that was a very substantial saving. So, the whole point, put the services out there, get away from the institutions, get away from the regulatory, institutional machinery, and teach people to function properly, independently, and then people don't want to go to hospital. You give them an alternative, they will avoid it.

PROF KING: Yes, okay. We've heard from some consumers who have said that there needs to be a choice for the consumers, about clinical care that they access, and the psychosocial supports that they access in the mix of those, including that the consumers may choose not to access clinical supports, just psychosocial supports. Your comments on that?

DR McLAREN: Well, I have no statutory power in my practice. I have no statutory power in Kimberly, I couldn't detain anybody. But if they were detained in the Kimberly, they had to go to Perth. And my job was to stop them going to Perth. And so I had to work by persuasion. It works, it's a lot more work, it's a lot more effort, it's hard work trying to persuade somebody with an axe that he really should put it down and come and sit down and have a smoke and a cup of tea. But if you've got to do that, that's what you do. So I totally agree, the option has to be available, but you have to have practitioners who are prepared to work in isolation, and can do so, and they should have institutional support.

I need to say that in the six years, my six years in the Kimberly, I was never once contacted by the Health Department of Western Australia, or by the College of Psychiatrist, or by the Medical School, or by the National Health body, Medical Board. Never once. Nobody ever contacted me. I could have been dead, I could have been drunk, I could have been doing anything and they wouldn't have known. As long as there wasn't this stream of patients coming down to Perth, they didn't care. And the College at that time was developing a conscience. I don't know what happened to it, but still.

They were running around telling everybody how they supported isolated psychiatry; no they didn't. No they didn't at all. I was the world's first and most isolated psychiatrist, but nobody else has got that honour, they've now got a team of people there. I got no support.

PROF KING: Okay. Julie?

MS ABRAMSON: I've got a few questions I'm wanting to ask, and it was about consumers having more access to information from their medical records. We had some conversations earlier. I'm just interested in your views?

DR McLAREN: Well, my records, everybody knows that they have full access to those. So they only have to request it, they will have immediate, full access. A couple of weeks ago, I had to type out somebody's report, because I use a lot of abbreviations, and I had to type it out so that they could read it. I don't have any problem with that at all. I think that's how it has to be.

MS ABRAMSON: What about the publication of outcomes data so that consumers would be able to say, 'well, that psychiatric institution has been rated highly by the people that have used it,' or 'that psychiatrist.' So, do you have a view on that?

DR McLAREN: I'd be a bit wary about the latter, 'that psychiatrist', because I practice pretty tough, sort of, psychiatry. I have people coming in, saying, 'I want him on' – 'I want the diagnosis for him. Then we get the money.' I say, 'No, he doesn't meet the criteria.' So, the immovable force – sorry, the irresistible force meets the immovable object. That's just how I practice. I have a lot of veterans coming in wanting benefits. I say, 'No, these are the criteria. This is it. If you don't meet it, that's it.' And, you know, you're not going to win a lot – I don't win a lot of brownie points like that, but generally I think, overall, people are happy with fair, open, straight-forward practice.

MS ABRAMSON: I guess what I was – thank you. Where I was coming from was, we're very seized of consumers being able to make choices. It's a Productivity Commission theme, so we're just trying to think about what – in what circumstances could consumers make some choices about the type of care that they're receiving, and outcome data is one of the ways that people can make a decision.

DR McLAREN: I think one of the things I do, routinely, is I give people a detailed account of the side effect of drugs. That's why I don't – I hardly prescribe anti-depressants. If you give people a list of the ten most common and debilitating side effects of anti-depressants, they don't want them. So of the 300 new cases a year, probably only 3 people will get an anti-depressant. And two of those will have had it in the past, and they say, 'I'd like it again.' 'That's fine, you know what you're getting, go for your life. Here's the side effects, read all about it, but that's it.' Only three – only 1 per cent of my patients get anti-depressants.

I did a study using the Hamilton Depression Rating Scale, which I have to tidy up and publish, and the average came back as extreme depression. That's the average of 100 consecutive referrals. Not one that (indistinct), practically none of them will get anti-depressants. They will get better, they won't go to hospital.

MS ABRAMSON: One of the things that we - - -

PROF KING: Sorry, can I just slip in. Sorry, Julie. But just on the anti-depressants, your view on GPs and their prescribing of anti-depressants?

DR McLAREN: No. GPs should not be prescribing anti-depressants, full stop. They're too dangerous; the drugs are highly addictive, they come with a huge raft of toxic side effects, and general practitioners don't have time. 'You're feeling upset? Okay, have an anti-depressant.' That should not happen.

PROF KING: Okay. Harvey?

DR McLAREN: Now, we've not actually met.

PROF WHITEFORD: No, we haven't. Nice to meet you after all these years.

DR McLAREN: Yes.

PROF WHITEFORD: So, obviously there are some issues with the way psychiatry practices, and the way registrars must be trained.

PROF KING: Yes.

PROF WHITEFORD: So, when you train registrars, or had experience training registrars, how do you manage them? How do you try and deal with the issues you see in their training, which is going to try and turn them into, you know, a psychiatrist that's going to practice in a different way to where they might otherwise end up?

DR McLAREN: The first thing is they have to have a model of mental disorder. If I see medical students, or trainees now – which is pretty rare, I'm kept right away – I say to them, 'On the first lecture you had, when the professor walked in, what did he say was to be the model of mental disorder that he would be using?' And they say, 'He didn't. He just started talking about brain enzymes.'

PROF WHITEFORD: Right.

DR McLAREN: So, you've got to give them a model of mental disorder, which I've, you know, worked on and published a lot about that. And that's the essential thing. The second thing is, they've got to have an understanding of how to assess patients. I have a very detailed, standardised form, which I follow. So it's something like 400 questions, they're all given in exactly the same order, same tone of voice even, to get the same information – sorry, to get the standard information, and then after that the patient talked.

But you've got this – once you've got this framework of assessment, the registrars feel a lot more confident, a lot happier. And they will – they freely say that. 'I wish we'd had this years ago.'

PROF WHITEFORD: One other question. So looking at your practice that you've given us plenty of examples of, how do you control for the patients who don't come back to see you who might not like, you know, your style or you know, the standard?

DR McLAREN: Yes.

PROF WHITEFORD: So the outcomes of those patients, would you know about that given you know, they're not the ones who do come back, who like the way you treat them?

DR McLAREN: Yes. There's a certain number who don't come back. I don't actually know what that number is because they often they will come back six months to a year later. That's – gets a bit difficult but yes, it's often it's – they want particular drugs which I won't prescribe, so I won't prescribe SH drugs. I tell them, you know, that I do not prescribe stimulants. That's it.

I will not prescribe them, sorry, alprazolam, and if that's what they want which in – as you know in Redbank Plains that's a significant problem. So if they don't get it, they will go away. Some of them want pensions. I say 'Well, this is the process. We will go through it.' And I actually have quite a good result in getting – in helping people get over that hump and so they're quite happy with, you know, what do we – how do we control for it.

Some vote with their feet. They just – they just want to come once, they want to talk. They're sort of happy with that. That'll do. It gets them through the crisis, then they just go back to life. And so a lot of it is just crisis intervention and people who generally are not terribly sophisticated. Very high level of unemployment, you know, people on pensions, broken families, a lot of drug addiction, et cetera, et cetera, et cetera. And you know, it's a working class area. A lot of immigrants in that area, a lot of refugees. So a lot of them just – well, a certain number of them are happy. They've come, they've had their talk. You're okay. Do this, do this. That's it. They go away.

So I have to see a lot of people under item 291 which is to refer them back to the GP.

PROF WHITEFORD: And do you have GP's who you work with?

DR McLAREN: Yes.

PROF WHITEFORD: Who you've got (indistinct)?

DR McLAREN: I work in general practices.

PROF WHITEFORD: Right.

DR McLAREN: My office is in general practices.

PROF WHITEFORD: Right, okay. So you work with those - - -

DR McLAREN: Yes, just walk down the room and say can – you want to know about this or they come and knock on my door.

PROF WHITEFORD: Okay.

DR McLAREN: I've always worked like that.

PROF KING: Your views on the role of psychologists and psychological therapy is the same sort of over-servicing that you view is occurring in psychiatry. Is that also occurring in psychology or do you feel that the approach that is taken through the various therapies is a useful approach? Just your views on that.

DR McLAREN: I'm probably not the best person to give you that advice.

PROF KING: Okay. No, that's fine.

DR McLAREN: Because I say to people if a psychologist can fix it, I don't want to see you.

PROF KING: Okay.

DR McLAREN: So 50 per cent of my patients are suicidal when they walk through the door. So the psychologists generally don't want to see them. I have a significant number of psychotic people, they won't manage this, which is reasonable. And over the years, you know, I've just got used to working without psychologists. I do my own cognitive testing, I do my own personality assessment. So I'm sort of working in a different – at a different level.

PROF KING: Okay.

DR McLAREN: I don't actually have much interplay with psychologists. And I really couldn't answer that question.

PROF KING: No, that's fine, that's fine. Yes, thank you very much.

DR McLAREN: It's my pleasure.

PROF KING: And the Queensland PHN's who – yes.

PROF KING: And if you could state your names and your organisations or who you're representing and then any opening comments that you'd like to make.

MR GORDON: Stuart Gordon. I'm the Chief Executive Officer of Western Queensland Primary Health Network. And I'm here representing PHN's for Queensland. We have a network and I got the long and short straw. But our PHN covers 56 per cent of Queensland, so I'm particularly interested in the impacts of mental health on those communities that reside in the more remote areas of Queensland and those subpopulations of Aboriginal and Torres Strait Islanders and older Australians that are aging and placed in very remote areas.

MR MARTIN: My name's Paul Martin, I'm Executive Manager for Mental Health and Suicide Prevention and Alcohol and Other Drug Treatment at Brisbane North PHN. So the complete other extreme of the PHN's of mostly metro, tertiary, quaternary services available

in the region. So we've got some opening statements that we're going to read. I've got the first section and then Stuart's going to do the second and then of course welcome questions.

So just generally, as Queensland PHN's we welcome and thank the Productivity Commission for its inquiry so far and it's report. I think we broadly agree with most, if not the majority of the recommendations and those that we don't fully agree with, we certainly agree with the intent, but have some suggestions around the implementation of those recommendations.

But for the purposes of our opening statement, we're just going to focus on three areas. One is our primary and community care, the second is the regional commissioning authorities and third regional and remote issues.

So in relation to primary and community care, so the vast majority of people with mental illness receive care from primary and community services. People at risk of mental illness or with mild to moderate mental illness need timely and easy access to treatment to resolve and recover from issues and illnesses and hopefully not have to ever use the mental health system again. People with enduring mental illness may need services to support and live in the community.

So we believe that a fundamental principle for our system should be that services and supports of people with a mental illness, both clinical and psychosocial should be provided in primary and community care wherever possible. With hospitals providing episodic treatment and care in times of acute need only. But we need to further build the capacity and capability of primary and community care to deliver services for those at risk of mental illness through to those with high levels of need, being support.

We need to support them in the community. Those – sorry, people with high levels of need in the community as well as people who have problematic alcohol and other drug use and suicide prevention issues. So we believe that primary and community care should stretch up to encompass the missing middle to support those people with higher needs rather than the hospital system trying to stretch down to reach those missing middle.

We believe that there needs to be a National Primary and Community Care Recovery framework developed to specify the evidence-based services that should be available to people in the community both clinical and psychosocial services. The framework would be then used by regional commissioning agencies to guide service planning and that framework should be in line with the National Mental Health Service Planning framework and there is a similar National Treatment framework for alcohol and other drug services that's currently in development which would serve the same purpose in the AOD treatment space.

That National Primary and Community Care Recovery framework, we'd also need to speak to the particular needs of population groups, Aboriginal, Torres Strait Island, coal communities and (indistinct) communities, age groups, but also conditions. So are there different – what are the different needs of someone with schizophrenia compared with someone with personality disorder, compared with someone with problematic, drug and alcohol use or suicidality.

We also need to continue to imbed the step care approach across the mental health system. And we support a range of recommendations in (indistinct) the Commission's interim report, around screening within general practice and Aboriginal community controlled organisations,

our initial assessments, integrated pathways and electronic referrals. Better linkages and phone services and (indistinct) health and to local services on the ground.

Increased investment into low intensity services including non-clinical and digital services. Increased investment for people with high needs to be supported in the community. That missing middle. Integration of clinical psychosocial and social determinate services, especially for those experiencing trauma and with high level needs. An improved client-centred digital interoperability and greater use of electronic records. And ability for people to receive more or less intensive levels of service as they're changing. So there's a whole bunch of recommendations that go to either directly or indirectly, how to imbed that step care approach into the whole mental health system. And we're still really at early days of that implementation in Australia at the moment

Funding data reporting systems need to be adapted to also be consistent with the step care approach. And we recommend strongly that a single national minimum data set for all primary and community care services is needed rather than huge numbers of MBS's which just cause confusion for service providers and are not much help for service planning.

On MBS and better access in particular, they are a large and important part of the primary care response, however, we agree that reform is needed in this area and we welcome the recommendation to evaluate their access. More can be done through the MBS system to support people with mental illness. Better access needs to reflect the step care approach however.

People at all the needs, all levels of need, can benefit from psychological services and MBS needs to reflect this, with people with low-level needs being able to access group work programs, and those with higher level needs being able to access a higher number of sessions, perhaps between 20 and 40, especially where psychological services are not available through the state system. For example, people with personality disorders who find it difficult to get into the state system.

We also support the recommendations in relation to extending access to video conferencing for psychology and for psychiatry. Our PHNs have played an important role in increasing access and appropriateness of services for people in rural and remote areas, and where there are thin markets or market failure in psychological services, and for underserved population groups like LGBT, Aboriginal Islander and children. We support the recommendations to enable co-funding of MBS related mental health items, and the provision of additional funding to out-of-hours services.

Any increased flexibilities and resources and better access should also be matched in PHN funded psychological services, to maximise the sustainability and efficiency of those services. Evaluation of better access should consider the work that PHNs and our providers have done improve access and appropriateness of psychological services. For example, providing psychological services as part of a wider package of care that addresses the root causes of distress, and some PHNs have moved to this model of service delivery, including more targeted support for people with chronic conditions.

For those with moderate to high levels of need, especially if there are other life complexities

or comorbidities, care coordination will be an important aspect of that person's care. The coordination of complex primary and social care needs should be recognised as a particular service type that can be provided either as part of regular care; for example, from a psychologist or a mental health nurse, Aboriginal health practitioner, or by specialist care coordination roles.

Partners in Recovery develop models of best practice and care coordination that are available to inform future investment necessary to achieve recovery in community settings. A key part of this, we believe, is the reintroduction of a modest, flexible funding pool, or brokerage funds, that can be applied to build individual capacity, and simply put, to prevent bad things from happening. For example, losing their housing, and ultimately, that saves money and illness impacts in the longer term.

So then in relation to regional commissioning authorities, Queensland PHNs support regionally based planning and commissioning - that's not surprising - for mental health problems like alcohol or drug use and suicide prevention. We also support pooling funds, wherever possible, into a single commissioning agency, and a number of us are already actively engaged in co-design and co-commissioning of services in various areas.

Our preferred model is the renovate model; perhaps also not surprisingly. PHNs have been established as regional commissioning agencies, and we believe that the investment in these organisations over the last five years should be built on, should be renovated. We do not support the separating of mental health from the wider health system, particularly primary healthcare. Overall, the health system is trying to work towards more integration, and in particular, the physical health disparity of people with mental illness requires us to integrate mental and physical health.

Separating the commissioning of mental health from the wider health system would work against integration, and be particularly problematic in regional, rural, and remote communities where health disparities are already greater. We agree that all stakeholders, especially governments, should agree on who is responsible for funding particular services through the proposed national mental health suicide prevention agreement, and revisions to the drug, alcohol - the National Drug Strategy.

As discussed above, we think that most services should be delivered in primary and community care. The agreement, the national agreement, would need to define where the boundary is between public hospital delivered services and primary and community care delivered services, because at the moment, that's all over the place across Australia, and there's not agreement on where that boundary is. We also believe that commissioning for psychosocial support should not be separated from clinical supports under any proposed model from the Commission.

From our co-design work with people with a lived experience, they tell us they want integrated, one-stop services, inclusive of both clinical and psychosocial services. This integration is made more difficult if psychosocial services are commissioned separately from clinical services, and some PHNs have already commissioned integrated service hubs for people with severe mental illness, bringing together engagement, assessment, nursing, psychological and psychosocial services, and care coordination, plus access to a wider range of services in the community.

And in small, close-knit communities, integrated generalist one-stop shop type service

arrangements are often linked to the local general practice networks to help normalise help seeking behaviours and encourage clients in accessing sensitive supports for stigmatised issues, such as drug and alcohol, or mental health concerns.

Under the renovate model, however, there is much more that can be done to further strengthen and develop the role of PHNs, and we support the recommendations around extending contracts to five years, removing requirements for PHNs to fund particular services, and the establishment of the mental health innovation fund to trial innovative health system redesign.

PHNs are already working in partnership with HHSs and the Aboriginal and Torres Strait Islander community controlled health sector, and we believe this should be built on. We propose that the commissioning of primary mental health and community services should continue to be devolved to the regional level, and we believe that PHNs and the HHS would form the commissioning agency with shared governance and accountability between the two of us, ideally including other stakeholders such as housing, employment, and of course people with lived experience in that governance arrangement.

And some regions have already been building this type of regional alliance between PHNs and HHSs, and we're happy to answer questions around that, and we'll be expanding on that notion in the national PHNs written submission at the end of January. Additionally, PHNs and the Aboriginal community controlled health organisation peak bodies have designed guiding principles for working together, back in March 2016, and these recognise the commitment to both improve the six key domains for Aboriginal and Torres Strait Islander health, including cultural competency, engagement, and representation.

It specifically notes the role of both groups, PHNs and ACCHOs in working together towards the vision of the implementation plan for the Aboriginal and Torres Strait Islander health plan, and an MOU has recently been signed by all Queensland PHNs and the Queensland Aboriginal and Torres Strait Islander Health Council, the peak body for AMSs in Queensland. However, if a separate statutory regional commissioning authority were to be established, we do believe that PHNs should have a key role in the governance of the RCAs. So, over to Stuart.

MR GORDON: Yes. So for regional and remote issues, the framework mentioned above, or that we've just outlined based on recovery, we'd obviously need to take into consideration some of those unique issues that impact on rural and remote communities, both in the planning and delivery of those services. There are some unique aspects about delivering services out there which requires a different approach. So some examples of that would be that there is a limited, you could call it market failure, but there's limited private services in rural and remote areas typically, and that's been in decline for many years.

There's also difficulty in recruiting and retaining a skilled workforce in remote areas, which is really well, you know, well recorded in the literature. There's difficulty retaining and recruiting specialist practitioners and generalists, particularly those with drug and alcohol, and that flows on to your ability to create an appropriate multidisciplinary workforce with good clinical leadership on the ground. There's ongoing funding to address negative impact of the longstanding drought and other climatic extremes, which is - I'm very sure, very clear to everyone at the moment how that's impacting on our farming communities and also our rural and regional communities.

The particular needs of Aboriginal and Torres Strait Islander communities, and refugees and migrants; greater linkages across the primary and social care to increase the visibility engagement across the social determinants of health which can have far more profound impacts in the more remote areas, drought and climate being one of them, of course, but also housing and education, employment, are all things that impact, as well as just distance, remoteness.

And it's well documented that the design of mental health and wellbeing services starts with local community input to ensure that all rural and remote mental health services meet the measure of the right care, right place, right time. A value-add for local design services is the need for longer minimum term contracts, which we've mentioned earlier. So with some longer view of establishing those right teams in the right places, and this is more critical in rural and remote, where you're seeing much more significant fly-in fly-out in the local workforce. So a really unstable workforce situation.

Which flows on not just to patients, but also for a PHN, our ability to work across a population, to get a population based approach or to work with general practices that are experiencing workforce turnover, or for them to retain good positions in those environments, as well as the impacts that flow on for patients that are needing planned and structured care.

So the evidence suggests that most people living in rural and remote communities access general practice, and that's certainly the case in Western Queensland, but I know across Australia it continues to be often the first port of call for all primary care, not just for mental health, but certainly our evidence would suggest that there's a significant burden of illness being managed within general practice that goes well beyond what we currently are funded to deliver, but obviously, with our sphere of influence, we were able to assist general practice in that redesign and Stepped Care approaches.

So consideration for capital infrastructure funding support co-location is really important. We heard from the earlier speaker how these relationships that happen across the clinical community can provide a great - can build a lot more capacity to those services by having them just under the same roof where they can have those informal interactions, or potentially having them co-located where they're working with other members of the team, and that's not always a - as we mentioned earlier, people with chronic conditions also managing depression and anxiety associated with that condition, trying to normalise some of the team care arrangements that are included in mental health can happen when you have a multidisciplinary team under the one roof.

And of course, we also mentioned the telehealth, mental health services being very important in rural and remote areas, but there are other challenges around the connectivity there. But still, as a service, and as a way of actually getting people in contact with care, telehealth is something that's been very well promoted through the rural and remote areas.

So in the final report, we'd like to see what more can be done upstream, because I think that's - that is where, from productivity perspective, our greatest gains would be made, and it will require more change to the way we currently do business. It does need to be evidence-based, and we've seen a lot of that, I think, uniquely through PHNs over the last four years where we've seen more of the low-intensity services and emerging non-clinical services that are being

proven to be really great tools, either for recovery or for prevention.

So better support is needed to help people cope with those significant life events, which are now literally manifesting in trauma. So in our Aboriginal and Torres Strait Islander communities, there still continues to be significant trauma that lies at the heart of some of the issues we're grappling with. But equally, farming families and small business that are being impacted on by what's almost been intergenerational drought, at this stage, and this climate change and those impacts create trauma as well.

So it does create, I think, a different - it's going to take a different approach to reach out and engage those people to keep them well, on their hind legs, and really having a long and high-quality life. So we recognise the significant role played by the private sector in delivering mental health beyond the MBS, and it really is the pink elastic that can bring more of that sensitivity across that mental health spectrum, whether it's in the psychosocial support area, or whether it's in managing people living in regional and remote areas with severe, long-term conditions.

The private sector's certainly a very important part of that puzzle, and when you lose that, then the default is often back to the statutory health organisations to try and cover off on a lot of the soft care areas that we're finding now in the evidence can be profoundly helpful for people in either early intervention or maintaining recovery in regional and remote areas.

PROF KING: Okay. Thank you, and can I commend, by the way, the Queensland PHNs for - you obviously worked together as a group in appropriate ways, and in collaborating. Some other states, that occurs, but I must confess, I wish we'd seen a bit more of it as we'd gone around Australia. So, well done on that. I'll start off just on the RCAs, and so the different structures for funding and coordinating services at a local level.

So, the sort of renovate model, and just for those who - I think someone said, 'what's the renovate model?', I vaguely heard whispered, someone say. So that's the shorthand for potential for PHNs, LHNs, or LHDs, or as they're called here - - -

MR MARTIN: HHSs.

PROF KING: HHSs. Yes. I can never remember all the acronyms. I'm going to call them LHNs, because that's what I know. Working together and coordinating; how do you think we could institutionalise that or - does it need institutionalisation? How can it be improved? Because one of the reasons why we've thought, well maybe we need a more fundamental bringing together of the state and federal money and a new body, is because going around Australia, some LHNs and PHNs work together very well, but some don't, and I think we had some evidence presented this morning where someone was saying, well, you get the PHNs where, yes, I work very well with one LHN, but they won't work well with another.

But it's a bit patchy around Australia. So how do we avoid that patchiness going forward? Because that patchiness is not going to solve - you know, it may mean the Queensland's great, it may mean that some other states are great, but it may mean that there's a great big hole in parts of Australia.

MR GORDON: Well, in my case, I have three HHSs that I work with, and ultimately I think you can't manage what you don't measure. So it's actually planning together about what it is that the problem is that you're trying to fix, and then also giving a common understanding around some of those fundamental principles of - like the National Mental Health Service planning tool, that prevalence tool.

I found that was a great starting point for conversations, to try and understand more what we should be seeing in our service, because if you're only counting what's coming through the doors, how are you measuring how well you're tracking from a population level, and that's where we're really trying to take the conversation. Stepped Care was important, because that actually helps to articulate how we need to configure the system so that, from my commissioning or our co-commissioning, where that's appropriate.

Because there are emerging co-design and co-commissioning things happening. The recent flood event in the north-west where there's been, you know, a lot of collaboration around jointly funding new positions on the ground, but they're typically kind of outside of the HHS remit, but hardwiring them into some community - you know, community engagement and linkage roles, the trade workers.

But Stepped Care, I think, does actually help to identify a couple of things. Firstly, how it takes a team to produce a good recovery program for people, particularly if they're in the HHS system, then often you have to nearly be broke, and you get into it. So we often find that general practice is managing a lot of patients where there's sometimes ambiguity between that exchange, when you can get into a HHS system, at what point you get discharged out of that system back into the community.

So that Stepped Care gives you an opportunity to think about that, what happens with the patient, where the focus is actually stepping them down into care. So having a narrative around what Stepped Care is together. So the importance of a joint plan which is something that all PHNs should have, or be working towards. If they don't have it, then it can be very difficult to identify how you can best collaborate and work to each other's strengths.

But where you do have a plan, I think they're the ones you'll see where there's a road map, and it won't always be - it doesn't just - you don't just throw the fairy dust out there. It's still all parts of the system you've got to change and engage with and modify and join up. But it does give you the framework.

MR MARTIN: And I think that a creation of regional commission authorities isn't guaranteed to solve that problem. So my understanding is that that's - the states would be tasked with creating some statutory bodies, and they did that with OHNs. But we can't say that LHNs across the country are operating consistently. So there's just as much variation between LHNs as there is between PHNs.

So creating statutory authorities that are governed by the states and territories, who are a step removed from government anyway; they have their own - usually their own board and executive director, and then a team of staff. They'll, over time, develop their own ways of doing things. So creating a dedicated body is not, I don't think, sufficient. I think we need to go back and look at the Fifth National Plan, so it does task PHNs and LHNs with regional

planning with co-commissioning, with using the mental health service planning framework and other things.

But once the plan is written, what's the actual levers, who's cracking the whip to get those things done? We've got the National Mental Health Commission reporting on implementation but it has no current role to press and cajole and twist arms and all those types of things. I think you're recommending that that role be beefed up. That would be good. So we go to all this effort of writing a national plan and then it just kind of stays on the shelf and we run off and do other things. So I think there needs to be some more accountabilities built into the fifth national plan, if that's the way we're going to go with things. It's already got some good strategies in there. How does that get translated?

With PHNs it's in our contracts with the Department of Health, our funder. It says you will do a regional plan with the local LHN. You will do this that and the other. I'm not clear whether that flow through comes through the (indistinct) into LHNs so that they have a contractual or whatever the equivalent is responsibility to implement the actions that are assigned to them in the fifth national plan. I don't quite see what the mechanism for ensuring the LHNs undertake those activities.

PROF KING: So where that planning has occurred and - with the LHNs, I'd be very keen on - because you said that it would be good to have more resources upstream, I think was the word that you used. Now we've heard the opposite where you're dealing with the LHNs or the HHSs but it's always more - the pressure is always more beds and more acute beds and we recognise there might be a shortage of acute beds but there's an even bigger shortage of the community beds and the community support. So I'd be very interested to know how you've dealt with that and also have you been able to bring the evidence - have you got the evidence base to be able to sort of put it on the table and say look here is the evidence that it's not - it is upstream where we need to spend the money.

That that's where we need to be going on our joint planning, and if you do have the evidence we'd love to sort of see it.

MR GORDON: Well, look, one observation would be that the HHS or LHNs see, you know, a very small part of the burden of illness that either is present or people at risk. So we've got to measure the impact with how do we engage and use our commissioning approach with the private sector, the community control sector, the philanthropic organisations like RFDS or other organisations that are really day to day seeing a lot more people, and who more do we need to engage. Is there pharmacy? Is there other - you know, the psychosocial program is a really important one because that's going to actually role out another whole layer, and to what extent can we enable things like NDIS. So we've just got to balance that engagement and I think HHSs or LHNs have - you know, they've got an enormous amount of skill in the game.

They obviously have infrastructure there, the support. People often they provide a lot of the specialist support as well, and I know our focus has been to really use that - use the shared understanding of who is who in the population via place based commissioning approach. So break it down to a level that you can actually digest. You can't kind of eat half of Queensland in one go. There's a lot of diversity across that patch and even in regional areas there can be a lot of diversity across a million - a population of a million people. So identifying how you

actually break it down to configure your service support to those places, and then identify what should you be expecting to see in terms of people that would be experiencing a severe long term - or a severe mental health condition.

And is that - you know, is that what we're seeing? Is that sort of - and how are we managing those people, and how are we - how are we actually moving those people back into the community settings? What sort of recovery are we putting around those individuals so that they don't end up back in hospital again or they're not back in there filling those beds? So you've got the - you do have to focus on getting that hard connection back in community, but that's what a balancing act is because unless you've got those services commissioned, and often the private and - or the other NGOs that are working in this space, then you've got to discharge people back into something.

PROF KING: But do you find the PHNs and the - or the HHSs are on the same page there or there's just different emphases that you have to try and balance, what's - - -

MR MARTIN: I think in terms of upstream neither of us are funded for that. It's outside of the remit of what the government provides us money to do. So I think if we're talking about upstream as in preventing people from getting into situations that are distressful, say a financial problem or relationship breakdown and so on, then the services that support people to do things should be nowhere near mental health services. People aren't going to go to a mental health service because they've got a financial problem. People want to go to more accessible, less stigmatised, easy to access services to help them with life transitions, help them with unexpected life events. So that that prevents the level of distress that then may develop into mental illness.

So that - those responses are better funded outside of the mental health budget, and potentially even outside of health. So we need to look at what our department or communities and equivalent are doing to - because the consequences of not dealing with that distress may have downstream mental health impacts but may also have criminal justice impacts, have economic impacts and so on. And so that's why it's upstreaming. If we can deal with those issues further up then it has (indistinct).

PROF KING: So you wouldn't see the funding for that going through PHNs? It would go through some other (indistinct)?

MR MARTIN: I'd see - not through mental health but potentially through - it could go through PHNs as wider health organisations.

PROF KING: Okay.

MR MARTIN: And certainly at Brisbane North PHN we fund through aged care and through the flexible funds that we have a small amount of from government. We are able to do some things moving towards that area, but it's not a specific bucket around - you know, for that social determinants work. That does need to be a whole of government approach, but there are some services that we can contribute to.

PROF WHITEFORD: So - sorry, Julie - -

MS ABRAMSON: No, after you.

PROF WHITEFORD: So you see the problem we're trying to solve with the regional commissioning authorities and I guess there are pros and cons too that you've mapped out quite nicely here, and the last thing I think we want to do is create a mental health silo in the community or separate - you know, trying to mainstream mental health into physical health because of the comorbidity issues that you've raised. But to follow on what the - Stephen's question, like my take on this is that we are dependent on people's personal relationships. In Metro North in Brisbane, that's been a good example I think of where the LHN and PHN have got on and worked together, but my question would be - we had Brett Emmerson here this morning, so how much is that about you and Brett - and when you and Brett go, what happens to that relationship?

Because I think what we're trying to do is say can we put a structure in place which doesn't depend on the personal relationships and the ability of someone like you and someone like Brett Emmerson to get on and work together, and the same I guess, Stuart, for you and the LHNs you work with around Australia.

MR MARTIN: I can give an example. So Metro North and the Brisbane North have developed an entity called the Alliance. So it's not a separate legal identity or entity but it could go in that direction, but it's a recognition there are some things that we need the two organisations to do together and that are greater than the two organisations and where we need to do things differently, and creating almost a neutral space to do new things in a different way, and that is jointly managed by the boards. So the boards of the two organisations have joint meetings, and have joint governance over the Alliance, and then the CEOs, then that goes down to the joint CEOs and so the manager of the Alliance reports to both of the CEOs.

And then the Alliance is staffed with a mixture of PHNs and HHS staff seconded in to form a kind of a multidisciplinary planning team, if you like, within the Alliance. So if Brett or I were to leave, those structures are all there because it's from the board through to the CEOs, through to the staffing. But that's there and would outlive any one individual and I think we're up to our third or fourth Metro North CEO in the time that we've had the Alliance. So it's withstood changes of CEOs at the HHS level. But we've just done that off our own bat, there was no direction for us to do that. We thought that that was necessary to do to tackle some of the big issues that we could do on our own. So there'd need to be some levers within the system to encourage, and enforce at the other end of the spectrum, that type of collaboration at the local level.

Because it absolutely is patchy across the country and sometimes it is down to personality or individual issues or styles of working, and others it's just, you know, HHS or - is in some kind of crisis and the time is not right to liaise with the PHN and, yes.

MR GORDON: In our case we've got the three, and very early on in the piece we - well, under the legislation there's - the HHSs need to have an agreement with their PHN or a protocol. So we've extended that to an accord, which really brings us together a couple of times a year, jointly planning, and that's been extended to all our community control organisations as well, so the (indistinct) and ourselves, we are facilitator and coordinator, but that's been going for

about 4 years now, and that's what provided some stewardship to our first mental health suicide prevention AOD regional plan which, you know, that was four years ago, and we – we feel we know so much more now. We're just embarking on the second one now.

So it's the relationships – and we've – there's been a few CEOs come and go there, as well, but the – the government structure is important, but I think where we – I'm seeing the best buy is the articulating place-based commissioned, where you find a way to actually get down to a level that makes sense to communities, and then support some structures where you can really harness the combination of clinical leadership that's probably untapped, or that's there and available, and also people with lived experience, some consumers, where they can, without prejudice, come in and talk about how we need to change things.

So that could be a – at Maranoa, we're developing a place-based suicide prevention strategy. That's been great for bringing clinical and non-clinical components together, including the HHS people. But also, I think, the model of care, which is important and now, for most (indistinct) I'll have a relationship with their general practice networks, and really that is where people are going. And if you're able to build the capacity of those general practice networks, and support them, create more options for people that are in a practice, for not just clinical supports, but non-clinical and social supports.

It does, we've found, that it really does help to address stigma as well, because, you know, if you're – obviously, if you've got a severe illness, everyone in a small country town, kind of knows who you are, and there's a lot of stigma all over the place about going into practice settings, but you need to customise care around those individuals. But to get into that, people that experience mild or moderate mental illness, to get them to reach out and actually come in and get across that stigma, then general practice, if it's well supported, can be – because, really, you don't know what you're sitting in there for.

So we found where we've put nine practices, we put mental health nurses in there. We've seen stigma that's been around with managed plan and structured care, like treatment plans, which is terrible thing to call them. They should be 'wellbeing plans', and they shouldn't just be such a one dimensional beast, they should be able to be customised a lot more around the Stepped Care environment, so that we can, as we mentioned – you can literally leverage from this to step people into care. Then you do reduce the stigma, and we have seen the doubling of people in Western Queensland that have had access to plan and structure care in the last 12 months, just through those general practice networks.

So you know if you can build the capacity, create some of that care coordination, and now being able to link in social care supports and things; they can be – and that's really close to the patient, because if you can actually discharge someone who's experienced severe illness back into a general practice, it's working at that level, with those relationships, and that helps to resettle them back in and get them into recovery, rather than – than the alternative, not being discharged into some other service that's not connected up. It's a long way to go, but there's good evidence that that actually can work, if you get it well supported.

MS ABRAMSON: Thank you.

PROF KING: Thank you very much. Next, Stefanie. Is Stefanie here?

DR ROTH: Sorry, I'll be with you in a second. My name is Stefanie Roth. That is Stefanie with an F, and Roth with a t-h. I represent myself, although I am the Queensland Carer Representative on the National Mental Health Consumer and Carer Forum, but I am not speaking in that capacity there, in fact I haven't been at a meeting yet.

I am speaking based on my experiences as a participant in ARAFMI Carer Groups in – or the ARAFMI Carer Group in Redcliffe, a Carers Queensland mental health support group, and the peer participation in mental services network, run by the PHN Brisbane North. And during this – so, I'm involved in, as a carer, approximately for the last five years, have been in the ARAFMI Carer Group for that time, but shorter in the other involvements, and I am becoming more and more aware that the carers meeting in those carer groups seem to be the ones that in the Stepped Model of Care, are at the complex and severe cases.

Because the stories that we share are about psychosis, schizophrenia, bipolar, borderline personality disorders, and so what we share is, for example, January meeting, three suicides. I was, I mean not – not involved, with my loved one. All that we share is a carer has a daughter, who in the last two years has had seven suicide attempts, because of bipolar disorder – no, not bipolar, borderline personality disorder, and would be covered in blood from self-harm, all the front, and would present to the emergency department with – to be met with a question, 'What are you doing here?' And so on. That's the examples.

Why I'm – so, so many points have been made during the day that I can't just read out my preparation, because it wouldn't apply, but what I want to get home is the – Mrs Hunter from Mind Australia, in Melbourne, spoke about the social and emotional model of mental health, and Ms Piu from Tandem spoke about relational recovery, as did the representative from MIFA this morning. He called it a 'person centred model of care'. And when these additional model of care – so, I do assume, I mean, you have the Stepped Model of Care. We talk about people oriented, or person centred system, so the question of course raises itself, what do we have at the moment?

If we need to talk about a person-centred, and a people oriented system, we seem to have something else. Is it medication oriented, is it machine oriented; what is it that people who are sick, who get treated by people and supported by people, don't have a system that is people oriented? I mean, face it.

So, in the questioning, what that was presented in Melbourne, one of the Commissioners said, 'What we try to do is make it very clear that, well, you can't have one without the other. That you can't have success in the medical model unless you've got things like appropriate housing and support and community.' But I don't see that in any way as – then Mrs Piu said, 'First of all, understanding what relational recovery means, that it's time to move from the individualistic model of recovery to one that's relational.' So it talks about inter-dependence, and then someone said, 'But I don't see that in any way as being inconsistent with saying that individuals are supported through their families.'

Now, what I've done here is, that is for the script, imagine that on the left hand side of the table there is a pile of documents that is approximately, let's say, a metre high. On the other side of the table three – a blue and two coloured Mentos, the blue is the clinician. The other two is the

consumer and the carer and around these are two, four, five green Mentos, they are the peer support workers and there's one which looks like a key. Then around there, there are three pens and they are housing support, justice system, and correction. When we talk about a psychosocial model then to speak in maybe economic terms, long ago I did a little bit of economic, environmental economics, the report is written very much from the macroeconomic perspective and that's the pile here that you can't see. But that's all the documents, all your plans, everything you have here and where, sort of, there is like rabbits, you know, one document creates another one.

Then, we have the microeconomic level which of course in this mental health context is not economic, I mean, it is run like there are CEO's and stuff like that but when we are talking about it, we as the carers and hopefully there's consumers and the clinicians or the support person, we are talking about healing. We are talking about completely different perspective and that is the production line. That is where you produce healing people, recovery is healing.

Yes, the funding all needs to be discussed and your lines that come down here need to – they need to meet. But if you do not develop a model that is understanding what actually happens here and I'm pointing to those Mentos, then you can't – it won't meet and what Niall's said, he left, is nothing will change. And the – so what needs to be put into here, for example, the triangle of care, Irene pointed to the guide, the practical guide of working with carers.

Well the triangle of care is not once in the report. You can do a search on 'triangle' it doesn't come up. And the triangle of care means that there is a clinician and a consumer and the carer. Now, talking about stigma, the carers are often seen as these disempowering, overburdening people who know better for the consumer what they need to do. That's, of course, not what we want but that is something we need to take into account as carers because there is a danger there. And when you guys talk about consumer and carer engagement it is a bit difficult, sort of, to always put us in one put. You know, there is not always an alignment of strategies.

But if we need to talk about triangle of care and all the issues about information exchange and do the carers need to know or the family, or whatever, for me it's pretty simple when you live in my house I am the accommodation, so I better be involved. If he doesn't live in my house, the role is different. And yes, we need to take into account human rights and consent and stuff like that, but the navigator of that relationship is not a matter of just look to the law of what does it say. It is what Irene said, a communication issue, it is a way how we converse.

In my experience the fact that Emerson mentioned this morning that the HHS is 50 per cent underfunded, of course means that when we want to talk to this guy here, we can't. It is, you know, in many cases of our carers you do not have a telephone number, you do not have an email, you are – this is no team approach. So what we want here is a team approach and we want that not just – I mean, you've written about partnership in the report but in the recommendation it's not in there. So what we know later, I mean, you know, with 1200 pages who is going to look at that? In the end everybody looks at the recommendations and - - -

PROF KING: So what recommendations – and apologies it's just been pointed out to me that we may only have the room until five and I hope somebody is actually checking up.

MS ROTH: Yes.

PROF KING: We're checking, sorry, which I didn't realise so my apologies. I assumed we would be able to go over.

MS ROTH: That's okay.

PROF KING: What recommendation do we need to bring that triangular care to make it work?

MS ROTH: The Department of Health should, based on the triangle of care, develop and implement best practice standards in collaboration with consumers and carers for what is going to be defined as a care coordination service for severe complex mental illness including AOD comorbidity diagnosis. These standards need to ensure that consumer and care (indistinct) are established through an appropriate communication model, refer draft recommendation 5.2 in my (indistinct).

The care coordination service should ensure that communication and interaction modalities, refer draft recommendation 5.2, are implemented that empower and enable consumer to develop human agency for their recovery and enable service providers to support carers for their roles of empowering consumers in their recovery process.

The success of this service depends and should be measured on the state machine effective therapeutic alliance and robust relationships with the consumer, for example, I mean just a trial.

PROF KING: Yes.

MS ROTH: I have more and I will put that in - - -

PROF KING: If you're able to put it in a submission?

MS ROTH: Yes.

PROF KING: Yes.

MS ROTH: But the whole culture of the report is about, you know, that there are attempts made to look at the emotional side of things but then it's information. You know, then people call help lines and they need to get the right information. Well, I'm a crisis supporter with Lifeline, so when you get a caller, 'I don't know what to do, I don't know what to do. I can't go on like this, I can't go on like this.' You're not going, like, 'Okay, just a sec. I'll get the referral for you.' You know, 'Just take a deep breath and think different thoughts and you will be right.' It doesn't work like that.

The report doesn't sort of, in the – it makes attempts all the time and I really commend you for that because it instils hope but when it comes to the point of how do we actually do that, how do we operationalise that, then there are shortfalls. And the other thing, it relies so much on what has been written before. I mean, the discussion here is so good and the plans that have been written are so good, why is it not happening?

You know, why is there no AOD person in the (indistinct) community mental health service. Most of the people that we have in the carer group have loved ones with drug induced psychosis. You know, and when you sit with a psychiatrist who, I mean, I read eleven years of training. You know, I have nine months of training and I have a better ability to talk to someone who is in crisis than this person. But when the person talks to my loved one and says, 'You know, if you don't want to be psychotic again you really need to stop smoking cannabis', and what does he say? He says, 'I take the risk.'

Whereas, Xavier Amador in the States who has written this book, 'I'm not sick, I don't need help' which you can translate into, 'I'm not addicted, I don't need help', 'I'm not whatever, I don't need help.' He has created a communication model which is called, 'Listen, empathise through your partner', that when you apply that you would solve so many problems. You know, it's - you would be able to talk differently to the LGBTI community to the Torres Strait Islander and Aboriginal community or even to Germans like me.

And so there is stuff there, but it needs – it needs to hit the road, it needs to hit the pole fence.

PROF WHITEFORD: Yes. I think we've got it. We've got it.

MS ROTH: You've got it good!

PROF WHITEFORD: Your diagram with – with the Mentos is – we won't forget that. You can be assured.

MS ROTH: Yes, that was the idea.

PROF WHITEFORD: That was a good idea. All right.

PROF KING: Any questions? Thank you very much for that. And we'll look forward to - -
-

PROF WHITEFORD: Leave your Mentos there.

PROF KING: So we have one more person who, yes, we're not going to quite get thrown out yet. Okay. So Melissa, thank you. Apologies for (indistinct) on time.

MS COSTIN: That's all right. I was just (indistinct). Yes, I might (indistinct) around my pens as well. Sorry, I'll just move the Mentos.

PROF KING: Yes. And again, just formally for the transcript if you could state your name, if you're representing anyone, who you're representing.

MS COSTIN: Okay.

PROF KING: And what you'd like to say.

MS COSTIN: Sure. My name's Melissa Daphne Costin. I was actually born Leslie Dawn Roose. I was taken at birth at the Royal Brisbane Hospital and given a fake identity. The

trauma of that, the trauma of being grown up with three violent biological boys with the people who adopted me who weren't ever disciplined for that, did damage to myself-esteem. I still managed to get a medical degree after multiple periods of homelessness.

And I started my first psychiatric medication as an intern. I graduated from the University of Queensland. I knew that Temazepam – I knew that Serepax and Mogadon and Valium were dangerous. I didn't even know what Temazepam was when I was taking it. I didn't even know I was on Benzodiazepine. I didn't know that Benzodiazepine - with a medical degree, I didn't know that Benzodiazepines made you depressed. Within weeks of being on a Benzodiazepine, working 84 hours a week, (indistinct) with my biological mother and my adopted mother fighting over who's the adopted daughter. I've not (indistinct) for the last 25 years. My father dying, patients dying in my internship, I ended up on – seeing a psychiatrist, being told I had major depression on SSRI. On the SSRI, I was manic. I was engaged to somebody I'd just met. I ended up having him threaten to burn my house down and burn my car out and then I had to flee my home.

I stayed on medication for six years while practising as a doctor. Declining all the way. Ended up on Effexor. So prexo epilim with him. And this was all a side of psychosis. With psychiatrists telling me to double the dose. Four years later, Effexor was listed with a black box warning for making you suicidal.

When I was presenting suicidal, I was told to stay on the medication and to keep – wait six weeks to see a private psychiatrist, who I'd gone to see for psychotherapy because my other psychiatrist decided they were only a pharmacotherapist. They would not speak to me under any circumstances about any of my emotional, social, developmental problems, my work related problems, my domestic violence, my homelessness, my abuse. It was all the medications. It was all the diagnosis. It was always take another drug, take another drug. Find another label. See another doctor. None of it helped me.

After having the dose doubled, in 2001, after having two suicide attempts, I overdosed one time. I – it was – I did 84 hours of emergency shifts. Seven – 8 pm – 8 am. In the middle of the night, in the middle of the bush on my own. I went to places like Wagga, Lismore, Lithgow, Dubbo, Broken Hill, Albury, Armadale, Dempsey, I worked in Tanner Creek, I worked in General practice around New Zealand, always on the run, always not being able to be by myself, workaholic because I couldn't deal with my emotional problems. I had nobody in psychiatry who could sit down and look at me and say, 'The drugs were a problem, you've got social problems with your parents you've got to work out.' They died, I never resolved any of that. I found the thing that saved my life was when my abusive husband who I married because I got pregnant because I was on SSRI and I was manic and I thought being pregnant to a stranger on the first day was a good idea, under the influence. Not warned about SSRI's causing mania. They're 22 and 20 now, they're doing okay but it was a very, very – lost my house, lost my kids, lost my practice.

PROF KING: What made the difference?

MS COSTIN: This is where I'm at, 2001, I ran away to Nimbin. Psychiatrists think this is the worst thing on earth. I stopped double dosing – I just want to say before I did that, I presented to – in my suicidal psychosis which was prolonged, I ended up having to (indistinct), I ended

up doing the skin cancer clinic cause – anyway, it was too much in emergency (indistinct) and all that sort of stuff. I had a solo – I was a solo GP, at Wolston Park who treated me as intern was the local psychiatrist when I was a GP. Every GP in Ipswich got invited by Zoloft, there was one before that but this one was by Zoloft, Century Cove, Highett Regency, all expenses paid, Moreton Bay Bugs on the barbie, beer wenches, footy, all expenses paid, your husband was there, free golf the whole lot. You just had to listen to him sit there and present vignettes from Pfizer saying that these drugs are fantastic.

I started taking my Zoloft as a GP that day from the sample packet, I took two. Zoloft was then told a couple of years later that it causes anxiety on starting so should take half a tablet. I took two which was four times half a tablet and with my weight not being the average, I probably should have been on a third of a tablet. So I was on six times the overdose. I was presenting to hospitals. Out of my mind, panic attacks, unable to cope. Now, I coped with a lot to get a medical degree from homelessness. I could not cope on Zoloft. I could not get anybody to tell me what was wrong with me. I lost my general practice, I ended up in skin – I did some (indistinct). Did a few more emergency private locums, ended up in skin cancer where I presented suicidal – for the first – I was working up in Cairns three days a week. The first three days, I just took pain stop because – to stop the ruminations. I spent every night sitting there thinking about all the different types of suicides of seen in the emergency department. Am I going to hang myself, am I going to burn myself, am I going to cut myself, am I going to overdose.

PROF KING: Jump to Nimbin.

MS COSTIN: M'mm?

PROF KING: Jump to Nimbin.

MS CONSTIN: But wait, in the Emergency Department I was left with the procedure trolley (indistinct) started cutting myself, nobody came to see me. Woke up the next day and then I was – didn't know whether I was sane or not. Anyway that was the last day I worked as a doctor. So in Queensland, my ex rang the (indistinct) agency to get me to work in New South Wales to apologise with the ski holiday for being suicidal. Overdosed again in a Canberra based hospital. Still (indistinct) Effexor, see the GP, psychotherapeutic psychiatrist. When I got to see her my husband had called and he talked to her and she was going to put me on Zyprexa, because he liked me sedated.

I looked at a script of Zyprexa, the double dose of Effexor and decided I wasn't going home, I was going to (indistinct), I drove to Nimbin. In Nimbin I had a joint, coffee, food, a decent sleep, I was able to talk to people. I love what you said about the café, being able to go there any time of the day or night, where there's peers, people who have gone through mental illness, who have escaped through psychiatry, have gone herbal, have got off all the prescription drugs, off the illegal drugs, off the heroin, off the speed, off the alcohol, off everything. Addiction is simply emotional regulation. People who are feeling intolerable depression, intolerable unworthiness, intolerable pain, intolerable memories, want to dissociate, they want to stop.

There is nothing wrong with cannabis doing that. It has got an (indistinct) of 25,000, you cannot overdose on it. You don't get the (indistinct), you don't get the sudden cardiac death,

you don't get diabetes, and you don't get psychomotor retardation. You don't get withdrawals like you do on (indistinct) and benzodiazepines. I had nothing but absolute (indistinct) cannabis.

PROF KING: Cannabis, yes. I'm sure.

MS CONSTIN: I've worked through the legislation in Queensland. Made submissions for the Queensland of TGA approved for medical cannabis use. THC 18 per cent flowers to inhale and CBD oil. On a disability pension that's \$814 for the flowers and \$280 for the oil and \$200 for a consult. Plus I've got to get to the Gold Coast for a script. I only get one week's script at a time, plus I have to go back the next day because the script has to be put in and the pharmacist has to dispense it. So it's over \$1000 or \$1400 DSP, all on (indistinct). The people who supplied me illegally have been busted and I'm talking about different people over 18 – I've been using cannabis for 18 years, since 2001. All my suppliers have been busted and there's been burnout with the fires.

PROF KING: What's your message for us, do you think?

MS CONSTIN: That there needs to be access for people with PDST to use cannabis through the public system. There needs to be a place for people with trauma and stress to be able to sit and relax. They don't have to someone on a clock waiting three weeks for an appointment. I went to QDN who put me – PIR who put me to MIF, each time it takes and weeks to get a phone call back and somebody's on holiday, and then they don't think you're well enough. I've been violently assaulted in public housing, I've had my head split open, and I've been strangled. When I tried to get help for this, I filed a (indistinct) good behaviour bond, (indistinct) Brisbane Hospital from QDN turned up the same day and admitted me involuntarily for five weeks on apripresol, epilyn, Lithium, Zyprexa, Valium, even though I said I had – well, you know, I've had personality disorders, all these things that you're not meant to be – and, you know, I've had problems with Temazepam, so I shouldn't be on Benzodiazepines. I had to fight off an RTO. I had them back at my – this was 12 months ago, and I had them back at my window when they made a complaint in to the Royal Commissions into Violence against the Disabled in their Homes.

The use of psychiatry is dehumanising. The labels have got nothing to do with what's actually going on. I could be called depressed because one day I'm sad, but if I get over the border, and then I'm in with good people, then I could be considered (indistinct). The same person is just reactive to my circumstances. I am happy that all of a sudden I'm not a mental drug addict, I'm just a normal human being like everybody else, with pain and problems and suffering.

I've never – PHN, I've had QFTAC, Queensland Fixed Threat Assessment – I've had psychiatry from Royal Brisbane Hospital come to me and say go and list at QFTAC for trying to get the police to discharge the person who did this, who lives next door to me, who has admitted to doing this to me, to police, at the crime scene, at the time. I have hospital records, I have police records, I have everything, and I'm still called psychotic. I'm still called delusional, I'm still called paranoid, because the woman still lives next door to me, because I'm dismissed for being mental, because I have a label.

PROF WHITEFORD: Because that label on you, yes.

MS COSTIN: Yes. And they won't take it back. They will not say to me, no, you have – sorry, after I got the ITO revoked the mental health review tribunal, they finally said I had complex PTSD. Until then, I was just a typical borderline personality, personality disorder. I've had the whole DSM. And I'm an adopted person with former – with no family, who needs support. I don't need to be judged, I don't need to be ridiculed, and I don't have to live – need to live in fear that my psychiatric services is going to drag me off, lock me off and inject me for the rest of my life, because my friends that have had that have hung themselves. I think it's an abusive service. I'm sorry, I'm angry.

PROF KING: No, no. I understand.

MS COSTIN: I've written to you about my concerns about the safety of psychiatric drugs. About – they wouldn't even admit the legislation exists. The policy of your (indistinct) is not supplying (indistinct). But they'll give me things that will kill me. The life expectancy of a person with mental illness is in the mid-50s. I'm on borrowed time. I've got evidence that shows that cannabis reduces mortality and complex medicine – medical – and I've provided, in my submissions, complex mental illness, the life expectancy of people who use cannabis, 45 to 55 is a 50 per cent reduction of mortality in five or ten years. It's lifesaving, it's a human right, and I'm getting treated like a psychotic criminal. That's my anger.

PROF KING: No, no, thank you.

MS ABRAMSON: Thank you for sharing.

PROF KING: Thank you very much for sharing.

MS COSTIN: (indistinct) psychiatrist. Don't drug kids, don't label kids. Positive parenting program that (indistinct) is the way to do it. I wish we could have a positive psychic program (indistinct) the situation. Eating, sleeping, rest and relaxation, safety, I can't get a job – if I get a job, I lose public housing, if I lose the job because of my mental illness, I won't get back into public housing and I'll be on the streets. I lived in my car to escape this person for years. I got threatened with eviction, they didn't help me actually deal with the person stalking me. And I'm – there's about 12 women living in their cars who have been violently assaulted in public housing, blamed by police and told they deserved it, when I was looking.

MS ABRAMSON: Can I just ask you one question: were you offered any legal support for the issues that you were dealing with?

MS COSTIN: Well, the police refused me. I went to (indistinct), who said they couldn't handle criminal, so they called the police. Because I was so – the only people that helped me was – so, they couldn't help me. Eventually I went to a new (indistinct). They helped me make a – put in my details to the police ethical standards, CCC, I get a phone call back, they said I hadn't made a complaint. (Indistinct) charged, as if. Anyway, so I made a complaint. The police didn't respond, but she escalated the – for a friend to get me back in the house again. I photographed that, took it to (indistinct), so then they said, they called the police, the police told me I was psychotic and took me to the psych ward, I was locked up. Discharged back into that, again.

The same thing, I'm seeing legal services now, but they'll – they've tried to help me with housing, housing say it's a police matter, police say it's a housing matter, eight years I've been played, had or with. Same, all the time, the woman who attacked me, looking in my door, outside my window, revving her car. I've got a video of some guy with her at the moment standing over the balcony talking about buying a gun, and, you know, what's the sights like as he's looking down at me. Totally threatening, or totally, constantly provoking - - -

MS ABRAMSON: Are you not, with legal assistance, are you not able to apply for an apprehended violence order, or something?

MS COSTIN: I made a (indistinct) good behaviour application. I (indistinct) the police in the hospital, and a (indistinct) they didn't come, and the judge kept saying, you know, how is this threatening? I said, well, she's blocked my front entry, her son blocks my back entry the last time I went through the door in that state, she stapled me and split my head open, I'm terrifying. They said, the Magistrate decided it was not threatening behaviour, but it was intimidating behaviour, which means it was stalking. The police came back up to my window, and I said to them, that's what the Magistrate said, they said (indistinct) I said, well (indistinct) and it's back and forth.

MS ABRAMSON: So you would be saying to us, very strongly, that there was a view about your discrimination, which meant that people didn't look at the issues, that you put before them, if I understand.

MS COSTIN: Yes. Yes. If I had photographic evidence, with a police report - - -

MS ABRAMSON: I understand.

MS COSTIN: And with the hospital enabling it. What the hospital had said to the magistrate, the magistrate came back to me and go, you know, after they hospitalised me, five weeks that day, from the distress of that episode, they were still having a go at me as if I was mental.

MS ABRAMSON: No, I understand. Thank you.

PROF KING: Thank you so much for that.

MS COSTIN: And, yes. So I think there should be more justice, less drugs.

MS ABRAMSON: Thank you.

PROF KING: Thank you. Okay. So, thank you very much. With that, I will adjourn the hearings for today, and they will commence again on the - - -

PROF WHITEFORD: Aren't they in Launceston?

PROF KING: On Monday. Yes, I was trying to remember the date. On Monday in Launceston.

MS ABRAMSON: I think it was the 9th.

PROF KING: So, thank you very much for your attendance today.

MS ABRAMSON: Thank you.

PROF KING: Thank you to everyone who's appeared. Thank you very much for your input.

**MATTER ADJOURNED
UNTIL MONDAY 9 DECEMBER 2019**



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

MS JULIE ABRAMSON, COMMISSIONER
PROF HARVEY WHITEFORD, ASSOCIATE COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

**AT LAUNCESTON CONFERENCE CENTRE, 50 GLEN DHU STREET,
LAUNCESTON
ON MONDAY 09 DECEMBER 2019**

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MS ABRAMSON: Thank you. Well, good morning, everyone. Welcome to our public hearings into our draft report for improving mental health in Australia. My name is Julie Abramson. I'm one of the Commissioners on this inquiry. My fellow Commissioner here with me today is Harvey Whiteford. Before we begin today's proceedings, I'd like to acknowledge the Palawa people who are the traditional custodians of this land on which we are meeting, and pay respect to their Elders past, present, and emerging. I extend this respect to all Aboriginal and Torres Strait Islander people in attendance today.

The purpose of this round of hearings is to facilitate public scrutiny of the Commission's work, and to receive comments and feedback on the draft report. This hearing in Launceston is one of many around Australia, in all states and territories, in both capital cities and regional areas. We will then be working 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, and then it will need to be publicly released 25 days after tabling in Parliament, which I think makes it August next year. We like to conduct our hearings in a reasonably informal manner, but I would like to remind participants that there are clear structures in our legislation for how these hearings are legally backed, and a full transcript is 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 they should be truthful in their remarks. Participants are welcome to comment on the issues raised in other submissions. I also ask participants to ensure their remarks are not 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, please approach one of our staff who will assist you, and our staff are just sitting over there. Ros and Lisa.

In the unlikely event of an emergency requiring the evacuation of this building, please follow the exit signs to the corner carpark at Thistle and Glen Dhu Streets, unless given an alternate assembly location by fire wardens. So, what we'll also do is we will have a little bit of time at the end of the day, so we are happy to take additional submittees at that time.

But if I could open by asking Dr Professor Dorothy Bruck; if you would like to commence, and if you'd like to read a short opening statement, that would be great.

PROF BRUCK: Okay. Thank you. Thank you, Julie. Welcome, hello Harvey. Yes.

MS ABRAMSON: If you could just announce who you are and where you're from. Thank you.

PROF BRUCK: My name's Dorothy Bruck. I'm speaking here in my capacity as Chair of the Sleep Health Foundation, a national not-for-profit organisation. I am an Emeritus Professor at Victoria University, with over 30 years' experience as an academic researcher and psychologist, specialising in various aspects of sleep-wake behaviour and sleep disorders.

This inquiry into mental health has already heard a number of presentations arguing it is critically important to consider sleep health in any review about improving the mental health of Australians. In short, there is a strong evidence-base that ongoing inadequate sleep and untreated sleep disorders are very likely to, firstly, increase the risk of subsequent mental illness; secondly, exacerbate mental illness symptoms; thirdly, decrease mental health treatment effectiveness; and fourthly, decrease mental health remission rates and remission durations.

So the first point is a question. If sleep is so important to help mental health, why not just use sleeping tablets? Sedatives are normally recommended only as a short-term solution within the medical profession; normally three weeks' use for an acute presentation. Problems with sedatives include addiction, tolerance, increased rate of falls, especially in the elderly, unrefreshing sleep, side-effects, interactions with other medications, and daytime hangover effects.

Studies show that people in the community are aware of the limitations of sleeping tablets, and are often wary of using them. The problems with sleeping medication exist where the sedatives are prescribed for insomnia that is comorbid or not comorbid with mental illness, such as depression, anxiety, schizophrenia, or post-traumatic stress disorder. There's conflicting evidence about the benefit of SSRIs for sleeping problems in those with depression, anxiety, or PTSD, and large individual variations in responses exist.

Sleep problems often remain, even for those with good daytime response to SSRIs. In some cases, SSRIs can be a useful adjunct to behavioural therapies for poor sleep. Over the last two to three decades, we've developed some highly effective and low-cost, non-pharmacological treatment options to improve insomnia, and this is specifically Cognitive Behavioural Therapy for Insomnia, known as CBT-I, different from normal Cognitive Behavioural Therapy. It's specific to insomnia, and also sleep apnoea, notably Continuous Positive Airway Pressure, known as CPAP.

With regard to the treatment of insomnia, many academic studies have demonstrated that CBT-I is more effective than sleeping medication in the medium and long-term. In addition, behavioural interventions that improve sleep have been demonstrated to have a large effect in reducing mental illness, such as depression and parasomnias, like nightmares, as may be seen in PTSD.

So my second point is that Australia has a big sleep healthcare gap. We know that there's a big gap between the extent of sleep problems and disorders in the community, and the delivery of effective diagnosis and treatment. We argue that this sleep healthcare gap contributes directly to the high rate of mental illness in Australia. The sleep healthcare gap, and its implications, have been well set out in the parliamentary inquiry report into sleep health awareness, entitled 'Bedtime Reading'. It was tabled in April 2019. We ask that this Inquiry endorses the relevant recommendations from that Bedtime Reading report. I propose to have a bit of a solution focus, I'm hoping, this morning.

MS ABRAMSON: That would be most welcome.

PROF BRUCK: In my written handout, that I believe you have on the laptops, we focus on solutions, and what I've done there is I've presented a series of tables. I start with a short summary of the economic costs of inadequate sleep, and juxtapose those with economic costs of mental health, and I also include some prevalence data. And the main tables below that takes the first three reform areas in your draft report, your overview, and adapts them, suggesting possible reforms to help Australia's sleep health.

The rationale is that we can improve mental health through the evidence-based, bidirectional relationships that exist with sleep health. So I welcome your questions and comments.

MS ABRAMSON: Thank you. I think we're also just dialling in your colleague, Dr Gemma Paech, by phone. I'm looking at Lisa. Yes. Thank you. Yes. On mobile. Gemma, did you want to add anything to the opening statement by Professor Bruck?

PROF BRUCK: She had her own opening statement.

DR PAECH: Yes, I've got some additional comments to make, just to support what Dorothy has already said.

MS ABRAMSON: Thank you.

DR PAECH: Okay. So I just want to start by saying thanks for the opportunity to talk to the Commission, and for the Commission in looking into a very important topic to a lot of Australians. Throughout this Commission, you would have already heard from a number of individuals and our sister organisation, Australian Sleep Association, about the importance and the bidirectionality of sleep and mental health.

So I'm not really going to go into more detail about that, other than to say that a lot of the times while disrupted sleep is listed as one of the main symptoms of mental health illnesses, disrupted and poor sleep can also lead to the development, as we're seeing, of mental health illnesses. In my opening statement, I would just like to highlight or focus more on how circadian disruption and circadian misalignment can lead to the development and an exacerbation of mental health illnesses, particularly depression and anxiety. So circadian disturbances - - -

MS ABRAMSON: Dr Paech, could I just - sorry, Gemma. Just a moment.

DR PAECH: Yes.

MS ABRAMSON: Dr Paech, could I just stop you there. Because it's a bit difficult with the phone, I didn't get the name of the disorder that you mentioned.

DR PAECH: Sorry. Circadian disruption.

PROF BRUCK: Circadian.

MS ABRAMSON: Circadian.

PROF BRUCK: Yes. Circadian disruption.

MS ABRAMSON: Yes, thank you.

DR PAECH: So this basically refers to a lack of alignment between the internal body clock, your circadian centre, and the external environment, such as a shift schedule or someone's sleep-wake patterns. And circadian disruption is something that's very commonly observed in a lot of shiftworkers and people that work around the clock. Circadian disruption alone can lead to increased risk of developing mental health illness, particularly in vulnerable individuals.

So there is people who already may have a predisposition, such as a family history or a history of mental health illnesses, and so it can exacerbate these symptoms in those individuals. Sleep and circadian disturbances can also lead individuals to being less resilient to stressors, so stressors at work or at home, which in itself could lead to mental health illnesses and - or could exacerbate these illnesses.

This could also lead to the development of other psychological issues, such as PTSD, and may hinder the ability of individuals to respond appropriately to stressful situations. So, for example, in emergency personnel, if they've had a lot of circadian disruption and sleep loss, and they're faced with a very confronting scene, they might not respond to that in the best or the most appropriate way, and this could lead to them developing further mental health issues, or worsening mental health issues later down the track.

Third, and depending on how the individual presents to a health professional, only the mental health illnesses often are treated, and not the sleep disorder or sleep disturbance, and this can be an issue for individuals, because as soon as the sleep disturbance, such as circadian disruption, if their shiftwork returns, the likelihood that the mental illness will return also increases, even if the person is treated, or has been treated, for the mental health illness.

Over the last few years, there's also evidence stating - saying that sleep disturbances are a risk factor for suicidal ideation, suicide attempts, and suicide itself. Suicide events are most likely to occur between the hours of midnight and 6 am, suggesting that wakefulness may directly contribute to some of the trigger factors. This particular link is currently being explored in Australia from the National Coronial data registry to confirm this in the Australian population, and what other factors may underpin it.

So just to kind of summarise, my general suggestions are that, as Dorothy would have mentioned, the Sleep Health Foundation will be putting forward more specific recommendations on the report, and how to recognise sleep health and the associated risk factors for the development of mental health illnesses. We also would suggest to incorporate sleep health into workers' compensation workplace safety tools, and workplace education, particularly for those individuals such as shiftworkers or emergency personnel people who work 24-hours, or around a 24-hour schedule.

It's also suggested that we look at screening for sleep disorders, and the treatment of sleep disorders, and not just the treatment of mental health illnesses, and then some public awareness around sleep health and its relationship with mental health illnesses, such as education promotion may be beneficial, and then education to GPs around sleep health and sleep disorders and how these lead to mental health disorders, and education about circadian disruption. For

example, shiftwork can lead to the development of mental health illnesses.

And then education for psychologists and psychology services around sleep health, and particularly resources on Cognitive Behavioural Therapy for Insomnia, which is shown to be more effective, particularly long-term, than some medications, which I believe Dorothy kind of touched on briefly there. All right. So that's my opening statement. Thank you.

MS ABRAMSON: Thank you very much. For the benefit of the transcript, that was Dr Gemma Paech from the Sleep Health Foundation. I have a couple of questions, and then I'll ask my colleague. We're very interested, as you will have seen, in young people and young people's mental health and early intervention. I am aware that in, at least in my home state in Victoria, that some schools are starting to have adolescents actually start school later, to recognise that their body rhythms are different. So I'm just interested in a practical way about some of those type of recommendations.

PROF BRUCK: I'm happy to answer that question. I believe there's one school in Victoria.

MS ABRAMSON: Templestowe, I think.

PROF BRUCK: Sorry?

MS ABRAMSON: Templestowe, I think. College.

PROF BRUCK: Okay, all right. Well, then there's another one. There's one in Mount Macedon as well that does start later, and there's a large body of literature around this that suggests that it's actually very beneficial for adolescents. But it's not without its potential dangers as well, because we know that puberty is associated with later going to bed, later rise in melatonin, and a tendency to want to stay up later and not get sleepy so easily.

And so we know that over two-thirds of young people regularly get only about - get less sleep than what they actually need on the school nights. Now, if you have a later starting time, in theory, that means they can sleep in a little bit. They're more in sync with their body clock, and then, you know, they just - everything works much better and they don't have that sleep deprivation. But we really need to have proper studies to - you know, field studies to know that this is the case, that they're not just even more advancing their circadian rhythm, that they're not all going to bed even, you know, two hours later than they normally would.

So, I think my short answer is yes, it sounds like a very good idea. It needs to be trialled. It needs targeted research to find out. I just know anecdotally from my own son's high school, what they did was the postpubescent children actually had to go to school an hour earlier for classroom reasons, and that just seemed to be crazy.

MS ABRAMSON: Thank you. The second question I wanted to ask is about GPs, and certainly in the context of our report, we've had some conversations about GP training, and it's like teaching. There's a huge number of things that have to be taught in the formal sense, but what would you be proposing with GPs?

PROF BRUCK: Do you want me to answer that, Gemma?

DR PAECH: It's up to you. I can add a little (indistinct) here. I think GPs, you know, traditionally they haven't received a lot of education around sleep and sleep health. I know in our area in - around Newcastle, a lot of GPs aren't very familiar with sleep disorders, and a lot of the times, whether because it's pressure from patients, or just because they don't have a lot of time, quite often if people present with a sleep disorder, they'll prescribe a sleeping medication, whether or not that's a sleeping tablet or something like melatonin, and they don't always try and investigate the underlying reasons as to why an individual might be presenting with sleep disturbances.

And so, education around how they can look for different reasons, or the causes underlying the sleep disturbance, I think, is really important, and then education around how they treat those patients, whether it be referral onto a sleep clinic, or referral onto a psychologist service, depending on – depending on what the patient is presenting with. I think a lot of GPs are very keen to learn this, whether or not they have the time and the resources is a different matter. I don't know if you want to add anything extra, Dot.

PROF BRUCK: Yes, I wouldn't mind just saying about sleep apnoea. We know that a conservative estimate is that 9 per cent of the population – 9 per cent of the adult population, may have sleep apnoea that needs treatment. Now, we can't have, and we don't want, the sleep community – the sleep specialist community doesn't want to be treating all those people. These are often fairly routine assessments, and then routine treatment, but the GPs need to be trained, so they can identify when sleep apnoea may be an issue, and what to do about it, and how to interpret the results that come back from a sleep test.

And the Australasian Sleep Association, our sister organisation, has been very clear in saying we don't want all the sleep specialists to be dealing with this vast number of people with basic, uncomplicated sleep apnoea. And so, the GPs need to be trained so that they can deal with those sort of things. And from a mental health point of view, it's absolutely critical, because the links between untreated sleep apnoea and depression are just extremely tight.

MS ABRAMSON: Thank you. Harvey?

PROF WHITEFORD: Thank you. So, staying with the GP for a minute, when the GP assesses a person, they may have both mental health problems and sleep problems, at the same time. And as you said, there's a bidirectional relationship between the two. So, in that situation, it may be hard to know which comes first, and is there any research you can let us know about, or advise about how they tackle that? Is it a case that you just go hard at both, or is there a way of trying to discern a causal relationship between the two?

PROF BRUCK: I think, if I can answer that, Gemma, I think that the key thing is that the causal relationship is not actually that important. We know that poor sleep is often a marker of mental health, and what proceeds one versus the other is not actually the significant thing in treating them. The significant thing is to recognise the primacy of sleep health, poor sleep, in exacerbating the symptoms and keeping them going, and the need to make treatment of the sleep problems complementary with treatment of the mental health problems. And if you're just trying to treat depression in isolation from the sleep problems that are presenting, then

you're not going to have nearly as a successful treatment outcome, short-, medium- and long-term, but particular medium- and long-term, if you don't treat the sleep issues as well.

So, we're calling for that gap to be narrowed, so for psychologists to have much more training in CBT-I. The APS, who I think are presenting after me, they have an online program for CBT for insomnia, and they have their members doing that. But that, the whole thing, needs to be rolled out much bigger across Australia, and one of the things that the Australasian Sleep Association and us have been arguing is that CBT-I doesn't have to be only the purview of psychologists; that there are numerous examples around the world, especially in the UK, where practice nurses have been trained in how to administer, and how to, you know, deal with CBT-I, and that's been very successful.

It's a bit like sleep apnoea. The issue is so prevalent that you can't just rely on psychologists to do it. That you need it to be in the whole Stepped Care Model. And psychologists have a really important role, especially when the mental health issues have primacy as well. But it can go broader than that, and must go broader than that.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Just one further question: so you put a very strong emphasis on educating – education. What do you think the barriers are for that actually happening? Because I think you've also mentioned in a recommendation that the government should be doing more in that space?

PROF BRUCK: Well, the Bedtime Reading report from the government inquiry recommended a national awareness, and we're adding behaviour change campaign.

MS ABRAMSON: Yes.

PROF BRUCK: Look, I think it's just not in there. We've had two reports recently, this draft mental health report, and the preventative health draft report, and neither of them mention sleep health.

MS ABRAMSON: This is why we have draft reports and have hearings.

PROF BRUCK: Yes, this is why I'm here. It's because diet and exercise have been pushed really – a lot, for the healthy lifestyle, but we argue that it's actually three pillars and sleep has to be the third one. And the reason why education – sleep is not there in the education, if we're talking about early intervention, is because it's not in the public consciousness, either. You think healthy, you think food, exercise – they don't think sleep, and so all of those, you know, people doing health education in schools need to have that education in sleep as well, so it's a whole lifting up of the awareness across the community so that it's ubiquitous.

PROF WHITEFORD: (Indistinct).

DR PAECH: I just want to add on to that point, if I can. Part of the terms around education, particular public awareness, is also some misinformation that gets put out there. You do have a lot of people that will report themselves to be sleep experts, but don't have any official

training, and I think the support from governments to recognise official bodies, like the Sleep Health Foundation, and the Australia Sleep Association as kind of the gold-standard for providing that education, as opposed to a lot of other individuals who might just read a text book and decide that they want to do that.

The other thing with training some individuals like GPs and whatnot is time and costs associated with it. A lot of them don't have the time, and a lot of them don't have the resources to access that training education.

PROF BRUCK: Could I just add to that; a lot of people think that helping sleep is about sleep hygiene, which is a word I don't like at all. But you know, sleep hygiene is a series of tips, you know, about caffeine and routine and thing like that, and it's one very, very tiny part of cognitive behaviour for insomnia. So I think part of it has been this misinformation that if you have a page of tips you'll be right, and that's far from the truth.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Sorry, one more question. So we've heard a lot about the ability to put CBT online, and either clinician moderated, or clinician not-moderated for common anxiety, depressive disorders, and a lot of research has been done to the effectiveness of this, as I'm sure you're aware. My question is whether CBT-I has been moved into an online CBT framework or not, and if it has, can you let us know where, and too, if it hasn't, would it be adaptable to that method of spreading it's coverage across the population?

PROF BRUCK: Do you want to answer that Emma, or should I?

DR PAECH: That's fine, I think you've got this one, Dot.

PROF BRUCK: Okay. Yes, CBT-I has been made online. There are a couple of programs that have been evidence-based, showing evidence-based utility. And I think the general feeling is that if it has the practitioner model in there as well, so that it's a therapist supported, the problem is that CBT-I for insomnia online is very sleep focused, as you can understand. And when we get mental health, mental illness, into the picture, it becomes much more complicated, and I think it's – you know, as a sleep psychologist myself, I think it's actually really good to have that face to face.

But I think that through telehealth, there's a lot that can be done. So, a combination of telehealth, online materials and trained psychologists, trained practitioners who know about CBT-I, I think is actually the way to go. I think, if we just expect people with complicated mental health issues, or acute – severe mental health issues to just do an online package, I think we're not going to get very far. Because the evidence suggest that they don't sustain it, unless there's that face to face interaction, and that concentration on their own particular manifestations of how their mental illness is affecting their sleep.

PROF WHITEFORD: So, can I just follow up on that. So, nevertheless, would it be important that in the various modules that we do see for the various targets that CBT online, I guess, comprise to provide some input, that even having CBT-I there, as an option, would raise awareness of the issues that you're pointing us to, and perhaps be a pathway to engaging in that

once you've become aware that it is perhaps a more significant component of what's going on or even maybe in the causal chain than would otherwise be the case.

DR PAECH: I would agree with that, yes, definitely. I think it's definitely got a place and the work that they've done in the UK shows that.

PROF WHITEFORD: Yes, so I wasn't suggesting that that is the answer to our problem but I'm thinking of trying to, I guess, create the awareness that you're suggesting is absolutely necessary in the area of sleep health.

DR PAECH: Yes, yes.

MS ABRAMSON: Thank you very much.

DR PAECH: Thank you.

MS ABRAMSON: And I think now we're going to dial in other people, is that right, Lisa?

PROF WHITEFORD: Thank you very much, Gemma.

MS ABRAMSON: Thank you.

DR PAECH: Yes, thank you.

MS ABRAMSON: Could I please invite Ms Knight from the Australian Psychological Society to speak and if you'd be kind enough to say who you are and where you're from and I'm sure you have an opening statement.

MS KNIGHT: Indeed I do, thank you.

MS ABRAMSON: And if your colleague would also be kind enough to announce her appearance for the transcript, thank you, and where you're from.

MS KNIGHT: I'm Ros Knight. I'm the president of the Australian Psychological Society currently. I'm also involved in training the workforce so I work at Macquarie University running training clinics for lots of psychs and I'm a practising clinical psychologist all of which inform my answers. So firstly let me thank you for the opportunity to present. I know you've got a very busy schedule so we're very grateful for this opportunity. We will be putting in a very comprehensive response to your questions in the draft report as befits a very broad discipline we thought we can speak to a lot of it so all I'm going to talk to today is just a couple of points where we think maybe there's some misunderstandings and a couple of gaps and the rest will be in our response and equally any questions you ask me I can't answer on the spot will make its way into the response.

So our overriding concerns when we look at the document around safety and quality of what's being delivered for consumers, the workforce capacity to deliver that for consumers and the sustainability, of course, of the budget and everything else that goes into making this roll out happen. We are yet to decide about whether we think option one or two are better options

because as befits most of what I'm about the say the devil, I think, is in the detail around - - -

PROF WHITEFORD: Options one or two?

MS KNIGHT: In terms of the RCA or the PHN modified model.

MS ABRAMSON: Yes, so rebuild or the renovate.

MS KNIGHT: Renovate, yes. So the detail I think is where we're sort of hesitating. So to talk through the main points for today I think it's really important that we communicate clearly that the psychology profession is very much in favour of outcome measures for the MBS process. In fact we actually think that there's a suite of measures that are pretty much good to go that have been trialled within the public sector and could be rolled out not just for MBS but also for PHN, headspace, private sector, and I think our main point would be to say while we're concerned as well that the MBS hasn't been appropriately evaluated we are concerned that probably no agency really appropriately evaluates outcomes that well for psychological services so we would be keen to engage in that but would like to see that rolled out across the board.

Now, clearly they have got to be appropriate measures. We can't have measures that are on the extremes so suicide rates per se is not a great measures of therapeutic outcome but neither is complete recovery sometimes so we just have to think about how we best measure, and particularly in different steps, what the outcomes should in fact look like.

Stepped care: again we strongly support the Commission's focus on trying to improve stepped care so again what we are more concerned about how we manage the steps between, without turning it into silos again because that's not helpful, but making sure that the people involved are actually able to produce what you need them to produce in terms of client care. So our sense would be that there's a lot of people who would like to be in this space and we would be - and think it's great, I want to say that upfront, peer workers engaging teachers to do more, nurses, GPs, all of that is all good. Our observation would be we don't want them to experience burnout and concerns because they start to overreach so making sure there's appropriate education and training around what they can do and when they need to pass that on is pretty important.

In terms of psychological interventions per se we clearly see that there's a role for psychology in lots of different ways from assisting say the peer workforce with supervision or the online programs again with sort of supervision and oversight all the way through to assists psychiatry who of course have significant numbers problems up towards the pointy end with particular areas of practice, psychologists, so, yes, overall again just saying we support the stepped care model and what you're trying to do but I think it's just got to be managed well so that we don't end up either in silos or are conglomerate of everyone who thinks they can do everything.

One of the areas in the draft document that caused us a little bit of pause was the assertion that we didn't need any more psychologists within Australia. We have had a look at the statistics and actually think we're actually relative to western Europe, we're actually underrepresented within the workforce so we actually think that may be a misstatement perhaps due to data that

was given to you but equally there's an assumption when we look at 35,000 psychologists that all of them are working in mental health or all of them are actually involved in therapy at some level and that's not true. We estimate from AHPRA's data, so this is available to the Commission as well, that probably around 50 per cent of the psychology workforce work in counselling or that sort of therapeutic intervention and the rest are working elsewhere.

Now, some of that is still stuff that would be relevant to the Commission and to mental health but a lot of it is not. For example, psychology management, consulting, research, organisation practices, those sort of things so over and above we're slightly concerned I suppose at the suggestion that we won't need more, we actually think we probably do and in particular you mention public system that everyone's leaving. Again, we would challenge the view that we're leaving because it's better placed work privately in terms of the finances. It's actually as much because the public system is very difficult to work within these days for psychologists.

Activity-based funding really needs a solid thinking about what that really means. A lot of psychological services aren't as simple as just sitting in front of a client and billing, that, you know, case work report writing that's comprehensive, all that takes time and if that's - and supervision - if that's not included in activity-based model then it's very hard to do your job. I also know that there are quite a few psychologists who struggle in private practice, most of us are part time in fact so the funding argument really doesn't carry a lot of weight.

There's also issues of course you've noted about getting out into rural communities and we should just encourage the Commission to think about ways to incentivise people to move out but also acknowledge the role of online and telehealth as being a fantastic option there. Probably the only other gap I would point out is that at the beginning of your draft you mention that this is not to do with neurodiversity sort of issues - - -

PROF WHITEFORD: Not to do with, sorry?

MS KNIGHT: Sorry, my mind's just gone blank. But not to do with dementia and other cognitive - - -

MS ABRAMSON: And cognitive issues, yes.

PROF WHITEFORD: Yes.

MS KNIGHT: We would argue that cognitive assessment however should be included. You know, we've said that in our submission to you and also into the MBS submission that it's really an artificial distinction to say that cognitive assessment doesn't inform how mental health practice works. It's been used even at psychosis levels but equally if we're talking about early intervention in schools, things like ADHD - you know, a decent assessment around all of that will help direct early intervention into kids but equally up the other end of the spectrum, you know, do we know if it's dementia or do we know if it's depression? So I think having sort of gone, 'Yep, we're not talking about that sort of thing upfront' I'm just enquiring whether that can be reconsidered. And that's it.

MS ABRAMSON: Thank you very much. I should apologise. We're having trouble with our Bluejeans so the phone in front of you is for the purposes of some of our staff and hopefully

Commissioner King who wasn't able to come today. Harvey.

PROF WHITEFORD: So just starting with the last question, the issue about - I think the trying to limit the scope to what we thought was manageable, I'm not sure we managed to do that but it wasn't to say that neurocognitive issues through the lifespan weren't relevant, it was more to say perhaps aged care, which was being dealt with by our Royal Commission et cetera, would be an area where we might put less focus on given the other areas we had to cover but certainly trying to understand the contribution that impaired cognitive functioning is making to individuals who may have psychological systems et cetera would certainly be within the scope and I agree that the availability of neuropsychological assessment hasn't been something which has been perhaps focused on historically or even maybe in our report as we could so we'd be interested in ways in which that could be supported. For example, there have been suggestions should the MBS be modified so that neuropsychological assessment can be done and reimbursed through that mechanism. If the Society has any comments about how we could remunerate that we'd be interested to hear it.

MS KNIGHT: Yes. I think because it can be a discrete item, it fits well within MBS but equally if it moved towards a more team-based approach of course it would fit within that model of package I suppose but at the moment under current funding options it would fit.

PROF WHITEFORD: It would fit, yes, and I think there was a difference between, you know, psychological evaluation and then the treatment or interventions that follow that which is a different question really as well but both important at this stage.

MS KNIGHT: Yes.

PROF WHITEFORD: So then coming back to the supply issue. Have you got data from Europe or the UK or where the ratio of psychiatrists whose population - - -

MS KNIGHT: Yes, 100-150.

PROF WHITEFORD: Right. I'm sure we've got that but I'd like to make sure we have got it. So that would be in your submission that's going in in January?

MS KNIGHT: Yes, it will be. We'll flesh that out in more detail definitely.

PROF WHITEFORD: Yes. And especially I guess the other issue when we're talking about workforce it's across the lifespan is also valuable for us. As you know we have done some work with the National Service Planning Framework (indistinct words) looking at workforce for child and adolescent versus adults versus older ages et cetera so we've found when doing that there tends to be an undersupply of mental health professionals circumscribed by age as well so again if there was any of that sort of information from other countries which have looked at this we would be grateful to receive that.

MS KNIGHT: Yes. I believe our written submission will have quite a lot on the child and family area actually but I've decided not to raise that today because that will just be answering your questions.

PROF WHITEFORD: Yes, sure. Do you have a question?

MS ABRAMSON: Yes, I wanted to ask you about private health insurance and you will have seen that there was a recommendation from us that we would actually like more to be able to be done in the community and I understand that of course that you're very supportive of doing that but I'd like to know what would that kind of look like, what type of services would you be thinking of?

MS KNIGHT: So if they were able to work in the community they could in the first instance act as a better add-on to the MBS so I know you've proposed up to 20 sessions which would be fabulous but at the moment of course the rebate from private health is very, very small and fairly tokenistic, if I may use that phrase, so I think it would have to be a more comprehensive package around that so that would be an obvious backup to the sort of clients that go into private hospitals, when they're discharged being able to provide some additional funding around services outside would be really good.

At the moment also as you know they have to participate in group to get services within the private system after they've been discharged and that's not always a great way to do therapy either, prescribing a particular type of therapy so - and in a sense is costing when it doesn't need to.

MS ABRAMSON: Just on that point because we've been talking about in community, as you know we're very concerned about regional services so I'm just wondering what sort of proposals you might have from your organisation that would support psychologists in the regions?

MS KNIGHT: So let me just say I really liked your PHN suggestion. I thought them topping up funding and providing some incentives was an awesome idea and definitely think the telehealth thing is also an awesome idea. To kill, we'll call it multiple birds of stones we did wonder about that ability to somehow if not start courses in regional and remote areas at least provide placements and internships out there. The psychology workforce struggles with appropriate placements and internships as it is within the system and I won't bore you with all of those details today but clearly if people have gone to a rural and remote area to do a placement or to do an internship they're more likely to stay if they can get work out there, if they've enjoyed it.

So we do think that model of trying to at least get some basic training - you know, medicos have to do a rural and remote placement as part of their thing so the difficulty there is appropriate supervision and things like that so that would be our main suggestion I think over on top of what you've already suggested and I'll just - yes, so the rural incentives like you say through PHN was probably not a bad way to do it.

MS ABRAMSON: Thank you. The other question too is you mentioned before about the payment from private health insurers being quite minimal. What sort of - do you have any data evidence about consumer willingness to pay and take up of services?

MS KNIGHT: We can come back to you with that. Through the private system do you mean?

MS ABRAMSON: Well, generally it would be very useful for us but the private system in

particular.

MS KNIGHT: Okay.

MS ABRAMSON: That would be very helpful.

PROF WHITEFORD: Sorry, that's the rebate for face to face psychological treatment, the higher private health insurance coverage packages that you were referring to.

MS KNIGHT: Yes.

PROF WHITEFORD: Yes. Compared to the MBS rebate it's much, much lower.

MS KNIGHT: Very.

PROF WHITEFORD: Yes.

MS KNIGHT: And I think prohibitive even for those who are paying quite a lot of money for private health insurance can't afford to pay that much over and above - - -

PROF WHITEFORD: Just on that though, we have heard that a number of the private health funds, you might have seen some of the media coverage on this, are very keen to offer community-based treatment for people who have been in hospital.

MS KNIGHT: Yes.

PROF WHITEFORD: Do you have any word on whether that would include psychology as well or you're not - you maybe haven't got that covered?

MS KNIGHT: We haven't had - - -

PROF WHITEFORD: No, so Medibank Private and BUPA and some of them are looking at persuading the government to allow coverage of non-inpatient and non-day patient treatment.

MS KNIGHT: Awesome.

PROF WHITEFORD: And we think that's a positive thing.

MS KNIGHT: Yes, yes.

PROF WHITEFORD: And I guess it would be useful to help understand for mental health patients what that means in the community given that some medical and psychological services are covered to some extent by the MBS what else would the private health funds cover and if they are going to cover that it would be at a level which would ensure that patients/clients could access.

MS KNIGHT: I think my comment there would be to say that depends on how much change happens to the MBS in the next little while so if we do extra sessions and it covers a broader

range of problems et cetera then whether they would just add-on, top up or whether there'd be particular things that they would be better focused on our hope is the MBS starts to actually address all the mental health needs of the community rather than a very narrow range of topics.

PROF WHITEFORD: Yes, so I think focusing, without wanting to pre-empt private health, would be interested in I would suggest that they're going to be interested in people who have been in hospital and are more likely to be readmitted to hospital. The MBS perhaps tends to focus on most of its activity on patients who (indistinct words) hospital and don't need to go to hospital so it could be complimentary if it's designed the right way and I guess we would be hopeful that in designing that the differences in those patients or population cohorts would be considered.

MS KNIGHT: Yes, yes. To me they're obviously different to the cohort that have been in public hospital with mental health issues, they're not as severe but still that same revolving door phenomena trying to put in place programs that will stop that from continuing, absolutely.

PROF WHITEFORD: That's certainly the intention, yes.

MS KNIGHT: Yes.

MS ABRAMSON: I just have one final question, I wanted to ask about school-based psychologists because I understand that you have an interest in supporting national standards et cetera, where we've gone in our review, as I'm sure you've seen, is for the wellbeing teacher in the school and a referral out to services and we're aware that I think both New South Wales and Victoria do have programs for psychologists but they're quite small in number I think given the cohort that they're to cover so I'm just interested in fleshing out a bit of more what you think in terms of psychologists in schools, what you'd like to see.

MS KNIGHT: So we agree that New South Wales and Victoria, it's fabulous what they're doing, that they're trying to make that presence felt and New South Wales has got social workers in it as well so it's trying to actually get a whole lot of stuff covered. We agree though that probably one in 500 - sorry, one psychologist to 500 is probably what we're looking at so for some big public schools one is going to really struggle to do that and probably the other thing I would add is it's - again, really like the wellbeing teacher concept. I think that's a fabulous idea. They would need to have a good sense of when they refer on who would they consult to work out what to do with that and trying to work out a more streamlined process to refer out because I know they often then get stuck going, you know, where do I send them? Do I just phone down the list of 20 or whatever, so I think there's a process there that - - -

MS ABRAMSON: I think in our model we envisaged - because we had a view that we would work to improve the support that's available in the community, which is why we were not focused on actual services being delivered within schools, but also in our model with the RCA we were also envisaging a close relationship with the local school community to deal with exactly what you've been talking about.

MS KNIGHT: Yes, and we're aware that in Tasmania there's been an effort to roll out a better program through (indistinct) psychs down here. So I think Tasmania has probably got a good example of something that is working a little bit better.

MS ABRAMSON: Could I also ask what role - we've had a lot of representations from counsellors.

MS KNIGHT: Yes.

MS ABRAMSON: And so I'm interested in your organisation's view of the type of roles that counsellors could fill.

MS KNIGHT: Sorry, counsellors as in?

MS ABRAMSON: As in general counsellors.

MS KNIGHT: At schools do you mean or - school counsellors?

MS ABRAMSON: No, no, as in - what's the best - - -

PROF WHITEFORD: So I think the issue is the difference in what counsellors - that's members of the Australian Counselling Association or PACFA can do versus members of the APS.

MS KNIGHT: Yes.

PROF WHITEFORD: And then clinical psychologists as you know versus - - -

MS KNIGHT: Registered.

PROF WHITEFORD: Yes.

MS KNIGHT: Yes.

PROF WHITEFORD: So that whole continuum of counselling or psychological care, treatment, whatever has been a real focus for the feedback we've received. A lot of it has been around where MBS rebates should go. But even leaving that aside, I think we want to understand - we'd like to understand in the Commission is where that workforce could be best deployed and urban versus rural or types of care. So where in your view does psychology fit into that versus counsellors who aren't - don't have psychology qualifications.

MS KNIGHT: Sure. Happy to attempt to answer that. I do actually work with counsellors so I have some experience of this nexus. Counsellors fill a great role in terms of - if I may answer it very detailed, in terms of helping people to work through their issues and come up with their own solutions to enable them to be heard, and then to come up with a solution. So the training therefore is much shorter. It's not about trying to work out diagnosis and implementing full treatment programs at that level but - and that's not to say they don't have treatment training, but it's definitely designed for - call it an early intervention sort of piece and that sort of basic level, which at some point needs to then be passed on if it turns out the person has more significant mental illness issues.

So that would be that bottom piece. My hunch - I'll speak a hunch, is just that for those who don't want to do online, who need the person to talk to in the first instance to help them work out what they're doing, that that's actually not a bad way for counsellors to be involved. That there is still a huge market for people who want to sit with somebody to work through their issues. So there's that. Working to the top of performance, all psychologists can diagnose and treat at least at a basic level for mental health. That's part of the basic training. So all psychologists fit in that middle ground of somebody who's now been diagnosed as - well, like I say it would be nice to be beyond depression and anxiety to a range of issues.

And working at the top of that level would be expected to do up to 20 sessions on a range of disorders, I suppose. And then moving more up to the pointy end as befits the PsyBA requirements, and we believe there's a range of expert psychologists who have skills in different areas. So if I use educational and developmental psychs are experts in the school domains and child development areas, as well as obviously clinical has got a name for itself in terms of severe mental illness. So it sort of moving up in that sort of area, was where - would be where we would see that shift over time.

MS ABRAMSON: I have just one final question which will show my ignorance, so please bear with me. Is it only registered psychologists who diagnose or is it clinical psychologists, and if so what's the difference?

MS KNIGHT: Like I say a basic diagnosis now under the training standards should come from any psychologist. The difference would be the degree of differentiation once it becomes more complex and comorbid that separates out the more AoPE type. I think that's the best way to put because it's not even severity, you know, somebody who's flagrantly psychotic, most people can have a pretty good stab at diagnosing that, but when it's complicated by a range of issues that's when it takes further assessment and intervention.

MS ABRAMSON: Thank you.

PROF WHITEFORD: I've got one last question also.

MS KNIGHT: Please.

PROF WHITEFORD: On the stepped care model we talked about - going back to the issue of counsellors for a minute, from you've said, counsellors could be deployed down the low intensity end of that continuum for people who have risk or who have symptoms that don't yet reach the threshold for a diagnosis et cetera, trying to I guess increase that early intervention component at the low intensity end. Yes.

MS KNIGHT: Yes.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Thank you very much, and thank you also for your continuing work with the Commission, it's much appreciated. Thank you.

MS KNIGHT: Thank you.

MS ABRAMSON: Could I please ask our next participant, Ms Martin-Cole. If you'd like to take the - I was going to say the stand because I'm a lawyer by training but it's not the stand, it's just the seat, announce your name and where you're from and I'd also invite you to make an opening statement should you wish to do so.

MS MARTIN-COLE: Yes, I'm Tracey Martin-Cole from Psychology CAFFE, which is in the north-west of Tasmania, and I had quite a bit I wanted to cover, so I have actually documented it. So if I could talk to that. We've been in the community for the past eight, nearly nine years and we were established in response to a community need in a rural regional area for child and adolescent services particularly. So I am a psychologist by training. Also a play therapist, and I'm a Board approved supervisor for psychology and also for play therapy. So Psychology CAFFE is a multidisciplinary group private practice. We started with just one building with six consult rooms and offering individual, family and couple sessions under MBS and private health, and helping children with autism and other funding streams and also full fee.

We now are expanded and servicing the remote and rural area of around 15,000 square kilometres across nine locations in the north-west. So we're actually rural, remote and regional. We're registered with the NDIS. We have several PHN contracts and we provide third party MBS and insurance consultations. Eleven per cent of our clients accessing our funding are identifying as Aboriginal, but yet only represent 3 per cent of the population in our area. Fifty per cent of our clients are children and 60 per cent of our referred clients meet the criteria for moderate or severe mental health presentations, including children and young people. So we provide supervision at the practice and training for peer support, officers for Ambulance Tasmania and we do prioritise consultations for first responders and other health professionals.

So we've grown and expanded and in the last financial year delivered 5000 individual sessions and several group programs to parents and children, including onsite and co-delivered in schools with other professionals and in early childhood settings. So we provide education and training for other services. We host workshops and deliver groups in the community for other professionals and organisations, as well as parents and carers. We host university masters students on rural placements in psychology, social work and medicine through UTAS, and we're also an organisational member of the Mental Health Council of Tasmania.

So it's a quite a large practice and we now actually are co-located in six locations, which is in medical practices and rural health centres in Deloraine, Sheffield, Devonport, Smithton, West Coast and Burnie. We - - -

PROF WHITEFORD: Sorry, run through those again.

MS MARTIN-COLE: Deloraine - - -

PROF WHITEFORD: Yes.

MS MARTIN-COLE: - - - Sheffield, Devonport, Smithton, West Coast of Tasmania, and Burnie.

PROF WHITEFORD: Right. Thank you.

MS MARTIN-COLE: We also have two standalone health centres in Latrobe and Ulverstone in very central locations, and we have a total of 15 mental health clinicians. They all have accredited mental health degrees and additional training and supervision. So they consist of psychologists, mental health social workers, a mental health occupational therapist, a mental health nurse and we're also co-located with a psychiatrist and a speech therapist. So we're quite comprehensive. We have lots of challenges. We have a lot of families with very low socioeconomic status. We have higher rates of mental illness and behavioural and emotional disorders in children, and we have acute suicidality in our community sector, much higher than most of the rest of Australia behind the Northern Territory.

So we have increased demand and severity in our community sector, and we've had a wait list for eight years. We've reduced it down to two weeks at times, but generally, it's up to 4 to 6 months for children, regardless of the number of people we can recruit. So, our biggest challenges are efficiencies with funding cycles that tend to be short, and a bit behind, often. So we have challenges with recruitment, with retention – the way we've addressed recruitment is to be a bit creative and persistent with our networking.

We've now, actually, finding it's much easier to recruit, but only because of the work that we've done over the past years, so we've increased our focus on culture within our team, automation of structures in our practice, so we've moved from a very traditional, private practice to quite a comprehensive, multidisciplinary team, and our retention has improved, with a strong focus on prevention of mental health difficulties in our own team, and burnout due to the pressure of the constant high demands, severity and complexity.

So we provide: weekly group and individual clinical supervision; regular training; whole team planning; and CPD days. We have static diaries – dynamic for clients, but static for us, so we close the practice, and we have an hour's lunch and those sorts of things. So, for us, our challenge has been, you know, addressed fairly creatively. The other issue for us is poor integration of the state and federal mental health funded systems. So, that's been promising for us to read that that's been looked at.

We're attending forums and community events as much as possible to advocate for rural/regional areas, and particularly for improving pathways between state and federal. Because we're in the community, and the commissioning's only really been in the last three years, what we've found is that the pathways aren't there, and so the documentation's about four years behind in terms of connecting up those two, you know, community and mental health services. So, for most of us, we've worked in mental health service settings, in the past, and we've moved into private practice so that we can actually be with our colleagues, and feel more supported and engaged with our community.

So now we're facing challenges of accessing psychiatry in particular, and that's across the board. Telehealth isn't very helpful for us, because you go to Strahan, and actually, if it rains, you don't have internet, so we have to drive there for two and a half hours to do face to face consultation. The patients/clients are often quite happy to see us, by phone, even, which fortunately the PHN has made possible. So, we're actually able now to deliver services that we couldn't before.

My biggest – my thought is that the biggest gap is actually for children five to 12 years, and families that have children in that age range. Our GPs, our referrers, our schools, the staff, are all quite distressed, and actually, you know, are finding that they're – the despair is quite high, because most of their work is now actually managing those families and children. Paediatricians saying to us, you know, 'I didn't get into this to help children with behavioural problems, I was here to look at medical issues,' and more and more it's becoming much more complicated than that. So, most of our referred children are actually in that age range. A lot of services for 12 to 18 in the community - - -

MS ABRAMSON: Is that the headspace services?

MS MARTIN-COLE: headspace, Cornerstone, our PHN is invested in that. There's the youth engagement team, which is for severe mental health in the community; recruitment's a challenge for them, training's a challenge for them. So we're often asked to provide that.

PROF WHITEFORD: Have you worked with that headspace team?

MS MARTIN-COLE: Again, it comes back to local relationships, unfortunately, and so building that with management, in a rural context, and the same with the CAMHS team, to be able to - - -

PROF WHITEFORD: Cam team?

MS MARTIN-COLE: Sorry, Child/Adolescent Mental Health in the State.

PROF WHITEFORD: State government, yes.

MS MARTIN-COLE: Yes, yes. So, the acute service. So we actually are still relying on relationships without our local area to facilitate those connections where there's cross-over, particularly in stepped care, obviously. Some of those youth are going there for one or two sessions, and then coming to us, but our funding doesn't support that. So then, the biggest challenge is accessing services, and being able to pay.

PROF WHITEFORD: Could you just run through here your funding does come from, overall?

MS MARTIN-COLE: Well, because we're a private practice, we actually have funding from every direction. We have clinicians that work, fully privately, so they will actually see children full-fee. Some of those families can access NDIS funding, particularly where there's co-morbid presentations. But other families access a Medicare rebate, but they still have to pay full-fee, because in a rural area – we've actually had some benchmarking done to be sure that we're cost effective, and then looking at, you know, our ratios, to admin to clinical for a GP to work in a rural practice, they can support a receptionist or a nurse, just with one practitioner. But in psychology, you can't do that, and certainly the rebates are – have been frozen, for, you know, the last nine years.

PROF WHITEFORD: You're talking about the MBS rebates.

MS MARTIN-COLE: Yes, MBS rebates.

PROF WHITEFORD: So, full-fee – when you say full-fee, you mean the schedule fee?

MS MARTIN-COLE: No.

PROF WHITEFORD: Or the APS fee?

MS MARTIN-COLE: No. Well, some of them are APS, because we actually have multiple third party payers, but our standard consult fee is \$180, or 120, depending on whether it's our principal or our senior clinicians, so the rebates vary anywhere from 50 to – well, 50 up to 120 for an endorsed psychologist, but we don't have any of those in that team of 15. We have several working towards that, that are registrars, but the majority are generally registered. Sixty per cent of our clients that are referred are actually severe and complex, so like I said, I have some concerns about workforce development, particularly with the MBS review, and the paper put out by the APS referring to the workforce, you know, and to what they call 'advanced practice'.

Because we're already doing that, but because we're in a rural/remote area, there's no recognition of prior learning accounting for since 2010. So, you know, for many psychologists and other professionals in mental health, because we are actually committed to working in a rural/regional area, we don't have access to those degrees that are APAC accredited, which are quite limited.

PROF WHITEFORD: 'APAC' meaning?

MS MARTIN-COLE: The body that accredits the degrees, towards endorsement.

PROF WHITEFORD: 'Endorsement' meaning? Sorry about this.

MS MARTIN-COLE: Area of practice endorsements, sorry, AoPE, which is addressed quite substantially in the APS paper, and is part of the reason that there are such a large number of submissions, I believe, to yours, and also the MBS review, in terms of the restriction of the practice that that represents, and the restriction of access. So, the argument is, given that we're not restricting your practice, people can come and see you, but the reality is that in rural and remote practice, they can't afford to do that. You know, the challenge as to distance and access and finance, because you've got much higher rates of unemployment, and much lower rates of education, and therefore, you know, much less capacity to pay.

So we have substantial PHN funding, as a result. We actually approached them a number of years ago now, and we've been delivering – so, this is since 2013, through the local PHN for Child and Adolescent Practice.

MS ABRAMSON: How does that work? Have they commissioned you to provide the services?

MS MARTIN-COLE: Yes, they have. Yes. Originally, just for children, and then we added parents, because we found that once you're in the community, particularly a rural community, it's very much word of mouth and reputation, and they don't – you know, they want to know what they're traveling or, what they're accessing is going to be of use to them. So, the primary mental health care minimum data set, which is a new version since 2016, has all of the data in there. So we would love – this year's the first year we've actually had really good feedback from them, in regards to the outcome that they're tracking in that portal. So, the evidence is there to show that what we're doing is working, but it's not really – it's a bit behind in terms of feeding that back. I'm not - - -

MS ABRAMSON: Can I strongly encourage you to put a submission in? Because, what you're talking about with the model, how you're doing commissioning and the rural and regional is really interesting, so I really encourage you.

MS MARTIN-COLE: It's a very – it's quite unique. We thought that – and it really has grown from the ground, in a very organic way, and we've had to upskill in the way that we deliver the service, and obviously implement policies, procedures and, you know, processes that a normal private practice wouldn't have, and then after that we've also had to look at the way that we recruit, and the way that we retain and train clinicians in our area, otherwise we wouldn't have enough. We don't have enough, and that is – I was pleased to hear Ros Knight say that, because, you know, the capacity, it's a challenge across rural and remote, of course, but also urban practices that I've spoken with, and I think that's a result of reduced stigma, increased awareness of the challenges, but I think that there are a lot of challenges for our children and adolescents that aren't actually, you know – we're not really aware of them adequately, I don't think.

So, to have hubs in schools, I think, is – or, in communities that are very closely connected to schools is really important, so I would love to put in a submission, and I plan to do that. It's just the time, because we're so busy delivering the services I think psychologists have a responsibility, if you like, to actually start to educate our communities about what we do and what we can offer and I'm finding that we're getting a lot of excellent feedback actually from staff.

Last week we delivered training to the kindergarten and early childhood staff at our local primary school around attachment and brain-based parenting, how that looks in the classroom, how that - you know, how to check how a child's tracking when they come into the classroom and what to do about that and where to send them if they think it's appropriate, that sort of thing. So, you know, at our recent youth mental health forum in Hobart there were a very - I was very impressed actually, there were a lot of paediatricians and GPs who had taken time out of their clinics to actually talk about it and that was one of the biggest outcomes was that we really need that in schools for 5-12 year olds, there's a massive gap. And also peer workers in schools, in senior schools in particular - - -

MS ABRAMSON: What does a peer worker look like to you because we've heard different sorts of descriptions?

MS MARTIN-COLE: Yes. So the first responder peer workers that we work with I love working with that cohort of very brave people that actually have stepped up in a volunteer role

to actually be available to their co-workers. From that we've actually had a lot of referrals of first responders for assistance with PTSD and, you know, they've been working in that area for 12-14 years and they've never accessed any assistance. Often sleep, as we've heard already this morning, is actually one of the first signs - or lack of sleep. And symptom of, you know, things not being quite in balance or correct for them so our focus is to help them look after themselves and find ways through that. I think you asked a bit more there than I've - - -

MS ABRAMSON: No, no, that's fine.

MS MARTIN-COLE: That's one version. And a peer worker in our practice, which I would love to have some funding available for that because I'm not sure - you know, obviously it's a private practice so it has to be billable time so I'm not sure how we would remunerate them appropriately but I can definitely see a place for someone to come in that's been - and we have multiple - we had a visit from a health minister, Greg Hunt, and also from Scott Morrison in the past two years and a number of families came in to talk to them about their experiences with mental health challenges, how it's impacted on their work, their capacity to work or engage in education because they're at home caring for children and for adults and for older parents that have mental health issues and health issues combined and they've talked at great length actually about how they would like to give back and help other families so I can see a role for a peer worker would be actually potentially a parent with adequate training and support that would actually be in the practice to help families engages and perhaps visit schools and go to homes when they're a little bit - you know, like, transport's an issue or they're fearful of accessing services, they don't know what that might look like, they can help them get to the practice, understand what that looks like.

I think there's quite a - New Zealand has a model that they're already doing that with young people and the young people; come in and they actually design the practice. One of the reasons we've been so successful is that a number of us have worked in hotel management when we've had other careers and so we've always had the - and I've worked for charity organisations and trauma centres where therapy starts at first contact, therapy starts at the door. You know, when I was working in the CAMHS team we actually had lockable swipe cards and airless - you know, no windows in the rooms, you know.

For a traumatised child to come into one of those rooms was actually traumatic on its own for us, you know, it's about the environment, it's about being engaged in the community so peer workers I think are young people and potentially parents in our case and other adults that could assist them to come and access services. I also think that would take the pressure off the practice team in terms of, you know, for us we used to be able to greet clients at the door, get them a cup of coffee, settle them in, explain the process, but literacy is an issue so filling out a form and then signing a consent form can be challenging. Now my team are so busy, and it's been phone calls and enquiries, that they don't have time to sit down with that person like they used to do so I think a peer worker would be invaluable in that place as well.

MS ABRAMSON: This is a really interesting model. My team are going to have a look at it here, the submissions are 23 January, but what you're saying today is really interesting so please contact us if that timeline's a problem for you.

MS MARTIN-COLE: That's okay, I can do that.

MS ABRAMSON: I wanted to ask you about stigma because clearly people are accessing your services and one of the things we've heard is a challenge in regional and remote is people not wanting to be seen accessing psychological services so you've obviously overcome that.

MS MARTIN-COLE: Yes. For instance, on the west coast of Tasmania you have a 30 minute drive average between Queenstown, Strahan and Rosebery which there are four main - and Zeehan is the other - there are four communities on the west coast. When we started delivering services we realised that, you know, the people that were living in Queenstown wanted to come and see us in Strahan and vice versa for - you know, they have relatives in those towns so that was a reason for them to go on a day off and actually visit but it also meant they were less likely to be seen by Fred up the street who might see them walking in.

We were initially sort of hoping to deliver services alongside the GP clinics, particularly given the remoteness and also the health centre but they were bang smack in the main street and so we actually chose to deliver our services in an office a little bit further away, that also helped. The clinic in Strahan were very supportive of us. We were told by the Tas Health Services, this is again state federal, that we would need to pay \$115 to rent the room to actually see the clients and we had to fill out a 15 page rental agreement to do that whereas, you know, we've just driven - it's a four/five hour trip.

We're only going to be able to fit three or four, you know, at most five clients in in a day so to ask, you know, it was such a hurdle to actually do that so we were fortunate that we had local people in other areas that were willing to allow us to use their space at no charge and that actually - we even deliver to the school because the medical centre one morning was locked up when we got there and we'd driven to another house and there was, you know, a client standing in the rain waiting to see us already so the local communities, you know, engaging with them and the school was wonderful and said, 'Look, you can use our library' which meant that children that were going to probably not access it easily were able to do so. So we've overcome it in quite creative ways at times.

PROF WHITEFORD: Have you found a difference in the GPs in the various areas you have worked in how collaboratively they work with you in your relationship between them; what makes it work and what makes it not work so well?

MS MARTIN-COLE: Yes. I think right from the start we've actually wanted to engage with them and actually have conversations literally across the table so we make time to visit with them at least once or twice a year if we can get there. We were told that, you know, to access the medical clinic and talk to the GPs you best take lunch and, you know, make a bit of a fuss about it. By the second visit they were buying us lunch.

PROF WHITEFORD: You had something they didn't.

MS MARTIN-COLE: Yes. Look, could you please deliver an in-service for us. We want to understand more about, you know, what is sleep hygiene versus sleep therapy? Like, how do we actually understand that? Why do we send you people, they don't get better? You know, we can have those conversations with them. The same with the paediatric clinics and the other services. We actually have to communicate with them. I occasionally come across a GP that

is very anti-psychology and other services that are and they usually come around once we explain what we do and don't do and the same in schools, yes.

MS ABRAMSON: Thank you, Tracey.

PROF WHITEFORD: So just to finish off on that. So it's a personal communication that seems to be very important and an education thing about the role of psychology where general practitioners perhaps just didn't understand it as they should have.

MS MARTIN-COLE: Absolutely and Mental Health Professional Network meetings have been invaluable for that as well where we actually get to communicate and network. They're actually nationally funded and that's very - a lot of it's done in our own time and it's not - you know, it's not billable time and so we have to really make quite a concerted effort after hours as well.

PROF WHITEFORD: Sorry, I know you need to go and we need to move on but one last question. Maybe there's a component of the client-base you see who might access paediatric services and child psychiatry services and need access to hospital inpatient beds; is that an issue for you in the lack of those beds?

MS MARTIN-COLE: Not just inpatient beds but also youth at risk of homelessness, you know, even at 12 and 13 due to complex intergenerational trauma, drug and alcohol use of the parents, and so I think it's not just inpatient units. Certainly the research overseas has shown that that reduces or the need for that reduces but we don't have any, that's the reality and so, yes - I worked in CAMHS in 2008 and they were talking about it then and they are still talking about it.

PROF WHITEFORD: And so your team works with CAMHS still for that specialist mental health - - -

MS MARTIN-COLE: Yes, we do actually co-manage occasionally where it's appropriate to do so, yes, because we have a clinical team and theirs is more acute crisis and intervention.

MS ABRAMSON: That has been incredibly helpful. Thank you so much for making the time to come today.

MS MARTIN-COLE: Can I just say I really am concerned, you know, about some of the limitations in the access to our services in our rural/remote communities if areas of practice endorsement get used to actually have a stepped - - -

MS ABRAMSON: We might need to understand this a bit more.

MS MARTIN-COLE: I need to probably put that in a submission.

MS ABRAMSON: Well, no, we've actually got some team members here and we would welcome having a further conversation with you about that.

MS MARTIN-COLE: Okay, thank you very much for the time.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Thanks, Tracey.

MS ABRAMSON: Could I please ask Ms Ross. If you'd be kind enough to say who you are and in what capacity you are speaking.

MS ROSS: Thank you, Julie. Thank you, Harvey. My name is Pippa Ross. I'm here as an individual, someone who has been through the mental health, and I'm putting that in inverted commas, pathway for many years since my early twenties when I experienced deep hopeless, despair and confusion. That was when I first started having counselling. I was fortunate to find an excellent psychologist who set a standard for all the other counselling I have received. He never gave me a diagnosis. He treated me as a person who needed to be told the truth, who needed to be listened to, respected and believed in.

I saw him weekly, at times twice weekly, and I paid for every visit because I had the means to. I was extremely fortunate. I wasn't working most of that time or was sometimes working part time but I was able to live with my parents so paying no rent and I had a bequest from a great aunt that enabled me to just make ends meet. I saw him twice weekly - sorry, I saw him weekly, at times twice weekly, and he also held human relations groups once a week. There was a lot of support and knowledge through those and I needed every bit of it.

Invariably participants in the human relations group would say, 'If only this was taught in schools'. These were adults who had already endured all sorts of relationship breakdowns and distresses in their lives. I continued my emotional wellbeing journey into the harrowing recovering of memories of sexual abuse much later in my life that had been totally buried. I have supported friends and family through both small crises and ongoing mental health problems.

Now, this is just a small request but I feel the whole concept of mental health needs to be reframed. It seems that we are approaching the issue from the acute end where human distress, trauma and relationship ruptures have been left untreated and already become a medical problem. By 'relationship ruptures' I mean everything from the lack of attachment of an infant with its primary carer, being bullied at school, being brought up in a violent home, fleeing persecution or war, to be introduced to alcohol or drugs early on in an unsupervised and uncared for situation, being homeless through lack of family support, trauma or enduring sexual assault et cetera et cetera.

We all understand the words 'emotional distress' but we recoil at the words, and I do too, 'mental illness' and I've never used that word for myself. I will just say 'emotional distress'. I feel because we use the words 'mental illness' and it's confronting, this is why mental health is not an attractive field to raise money for, to talk about openly or as we've heard here for nurses to work in. Mental health is not brain health, it is being able to maintain satisfying and relatively peaceful relationships. It's about having hope and the ability to hope for a future for one self. It's about being able to love and be loved. It is about having meaningful work or pastimes or participation in society. The word 'mental health' implies there is health and there is sickness and some are unlucky to fall ill with mental health when in fact we're all vulnerable

to it if we have trauma or serious relationship breakdowns or illness, through so many causes.

The so-called mental health landscape to me looks like a blackened landscape we've seen recently on our TV screens after the bushfires where emergency services are doing an amazing job keeping people alive. Same with mental health; we've heard at these hearings about people doing amazing things to help those at the acute end but we need to take care of the whole area of relational health way before it is domestic violence, severe drug and alcohol abuse, addiction, homelessness or suicide. We're treating the symptom and not the cause. All these are the result of untreated trauma or distress, inability to communicate, isolation, failure to build self-esteem and other relational problems. These are relational problems and not medical ones.

What emotionally distressed people need is to feel safe, to be listened to, to be respected, to be understood and to have company. Loneliness and social isolation is a huge part of being emotional stressed or unwell. When we're emotionally fragile we need to be with people who are well, who aren't strung out themselves, who aren't fighting their own demons. Putting emotionally distressed people into group homes with other distressed people doesn't work I feel. I've heard the phrase 'community-based mental health services' and I'm not quite sure what they are exactly. If this means putting people with mental illness together into group homes with a supervisor or people living in group accommodation without a supervisor, my question is, what are we thinking?

Through my church in Brunswick, Melbourne, 15 years ago we visited rooming houses where there was no supervisor, 20 or so men in a large old house all with drug, alcohol, gambling problems, some fresh out of gaol and of course some we didn't know what their problems were or most of them we didn't. Some houses were for women only. A roof over their heads, yes. Support, no. Safe, not really. Chance of rehabilitation, probably nil. They wouldn't have appeared in the homelessness statistics but the truth is it was only one step up from the street. In fact, maybe more lonely since most of the residents didn't communicate with each other out of fear and self-protection. We would turn up with simple meals and residents would come out of their rooms, take their food and return to their rooms with barely even a word to ourselves or each other.

Also in Brunswick there was, and still is, a supported residential service. SRSs are privately operated businesses which determined their own fee structure and the services they provide. I visited a man there with psychiatric problems and I found the place chaotic and distressing. He would just stay in his room. The place houses 20 residents all on pensions all with huge problems. I talked to the staff there last week and was told there are no activities at present. I personally don't think there ever have been activities for the residents, basically it's just a roof and food. I would often see distressed residents walking the streets. I know that when we're in deep distress we need safety, calmness, kindness, help with daily tasks like food. We need an asylum in the true sense of the word. Loneliness and isolation is a huge part of being emotionally distressed or unwell.

Emergency departments or the street are no places for people when they're in that situation which brings me to a solution that is practiced in various countries of the world and one place unbelievably for over 600 years but the others since the 1950s. Belgium, Canada, United States, France, Sweden and possibly more countries all practice a system of supporting and

even rehabilitating psychiatric patients by placing them with ordinary families or foster homes. The town of Geel, I'm not sure if that's the right way to pronounce it, in Belgium is the oldest and it allocates people sometimes with schizophrenia or who have had psychosis to a couple or a family where they live as a member of that family joining in the activities as they are able, contributing to the running of the home.

In 2018 there were 205 boarders living in Geel. Geel's medical professional will say the system makes a lot of sense. Boarders have better outcomes than patients in hospital, they take less medication and have few acute episodes said someone who works in that area. A group of therapists and nurses support the household, the host and the guest with 24-hour access - ignore?

MS ABRAMSON: Yes, ignore it. Lisa's come to the rescue.

MS MARTIN-COLE: Okay, I'll take that opportunity, I'm getting a bit dry. I'll start again. A group of therapists and nurses support the household, the host and the guest with 24-hour access to health if needed. The guest receives therapy from the support team but in the home the person is just treated as a guest where their host may have – will have no idea of any diagnosis. And hosts aren't trained in psychiatric care.

The guests are assigned a family after being assessed in a hospital and after any acute psychotic or schizophrenic episode has finished. Any guest with a history of violence or abuse of others, of course, wouldn't be eligible. The hosts are paid an allowance which is way below the cost of an acute hospital bed and below the cost of community care.

Under the Swedish scheme called Family Care Foundation, residents might stay for several months or a year or two, all the while supported by regular counsel and therapy. The aim is not to diagnose and label, but to treat each person as someone who needs love, care, support, stability and peace and most of all, company.

Sometimes our family of origin is not the best able to help us when we have a mental illness. Now, I just want to talk, if I can about the medical model versus community model. Mental health can be viewed as a medical problem that only GPs and medical specialists know how to fix.

Or it could be seen as a relational problem that untrained people can help with. It can be seen as a field for experts or it can be seen as a field where the person suffering can be helped to work out what they need.

The alcoholics anonymous model which I don't have direct experience of, but I know various people who have. The AA model has been successful for so many years around the world, because it's centred on relationships as a pathway to healing. Relationships within the group, the sharing of common experiences, sharing of knowledge about alcoholism, observing those who have broken free of addiction and also the close sponsor role where someone who has been sober for years takes a new member under their wing and is available. Sometimes 24 hours to listen, to talk and support.

I have been to peer led residential retreats through Heal for Life in New South Wales for those who've suffered childhood trauma. I could find no one else in the country who's doing such cutting edge therapy or offering such profound help that is available there.

I sometimes thought myself that if I'd had a drug or alcohol problem I would have received much more help and support that is, through AA or just the supports that are out there. But having depression and anxiety and low self-esteem didn't warrant such help. I felt invisible. The medical model also sees that nursing trained infant welfare sisters are the ones to manage the early years of humans being – of a human being's life, (with the mother of course, or parent.) They have very little training in giving psychological and relational help to mothers. In those early crucial years, a child has been seen as someone who can be attended to solely by the medical profession. Maybe there is need for more peer support and again to bring this outer medical model of dealing with human beings.

The idea of infants being assessed for mental health problems gives me the heebie-jeebies. Give mums the proper support they need before they take the baby home and you might be part-way towards having good outcomes. So many mums I know have had a very difficult time after being discharged from hospital two days after giving birth before even breastfeeding is established. Before they have overcome the drama of birth. Before they have been able to catch up on a bit of sleep.

I can't imagine being assessed by inadequately trained or inexperienced people with a rudimentary knowledge of depression. Already anecdotally, infant welfare sisters are looking for depression behind every bush whereas in the past, everyone new that mood change is a normal part after a significant event such as birth. Infant welfare nurses need far more extensive training in psychological and social development of a young child and how to help families, especially in crisis.

Young women now often have very little contact with infants, toddlers or even children. They have full-time jobs before giving birth. An infant welfare sister I know here in Tasmania said yesterday that 'Loneliness and isolation for new mothers is a big problem since they have often been working up until the birth and have no – may have no family support. Maybe that's another opportunity for non-professional peer support.

Grandmothers for generations know how much a new mother needs support, company, feeding, rest as she eases into the new role of mothering an infant. There needs to be so much support in those first days and weeks after birth. I'm not sure whether short stays in hospital after birth are due to funding constraints but everyone needs the opportunity to have a longer stay especially if they have no support at home.

I have supported family members myself in the last few years. One with a partner, one without. Both were at crisis point after being released from hospital and assuming they could do it on their own. Thank goodness they asked for help. And after that, they were fine. I'm going on, is that okay?

MS ABRAMSON: We're at time.

MS ROSS: Right.

MS ABRAMSON: But if there's something in particular that you want to say, please. We just won't ask questions, that's all.

MS ROSS: Okay. Well, I really believe that we – I don't agree that schools are too pressed to introduce relation and wellbeing into the classroom. Schools aren't too busy to do drug education, sex education, the topic of bullying, different sexual orientations. I'm trying to precis it. Drug education at present starts in primary school. There's no point teaching children the dangers of drugs if most drug and alcohol addiction is underpinned by trauma and distress.

Sex Ed is taught in schools. No point in teaching it without teaching more about relationships. Bullying is a huge problem and most schools seem to be grappling with it. It's a bit late to ask a mate how to express how he is going at 40 years old when his wife may have already left and he may be alienated from his children. Better to get him to talk about himself as a child or a teenager. And just a couple more points. I think the cost of individual therapy is outrageous.

How on God's green earth can anyone justify charging \$300 a consultation for 50 minutes as some psychiatrists do. Again, group therapy is a cheaper alternative or as an adjunct, but it's often not talked about or I don't think there's enough available. I do not believe GP's are equipped to manage mental health care plans. They are trained in the most rudimentary elements of mental health as a previous speaker in these hearings, I think he was a psychiatrist, stated.

Another GP, another speaker, a GP claimed her job in matching patients with their therapists is like being a matchmaker. I feel she is unique. She understands it is a good therapeutic relationship that can bring healing or at least comfort and maintain stability. GPs don't have the time or information to match a patient with a therapist or counsellor. They also may not have the interest or knowledge required.

Many people are unaware that a patient can find their own therapist and then ask for a mental health care plan. For years, we had hoped for subsidised mental health, but it has backfired in some ways, I believe. Ten sessions is not long enough to find a therapist you get on with. Some you won't and never will, so that might waste two or three of the sessions, then you've got seven or eight sessions to get to the bottom of the problem. So counsellors are rushing through to get patients sorted in 10 sessions because now there is this expectation you will get your problem sorted in 10 sessions. When I don't think that's ever been the view of psych – therapists in private practice.

I know friends with severe trauma in their background who have been assigned to – through their GP – to psychologists in their area, in their country town. These friends were – this friend was – one of the friends was not willing to allow me to share the details of her trauma, but no one would argue that she didn't need long and protracted support. This psychologist told her to practice mindfulness and another one said, 'Sit in the sun and listen to the birds.'

Which brings me – I'll just finish now, if you like – to accountability. There's no accountability for the GP referrals. No accountability even for psychiatrists. I think it's incredibly hard to complain about a treatment at the hands of a psychiatrist. And I think most people just don't bother. In – I'm talking about private practice - well, also public health.

I have a young man who's come to stay with me and he had – he had severe alcoholism for the last five years and he went to detox several times and he had to be admitted under a psychiatrist. He said that psychiatrist would spend the maximum of 10 minutes with him at each talk he had while he was there. And he just said, 'There's nothing wrong with you,' and 'Just keep exercising.' And also suggested he join the local tennis club. This man was drinking himself to death.

He came to stay with me because I have listened that model of - I've been very touched by that model of taking people into the home and loving and caring. He came to stay with me on my farm and after a while he opened up about a trauma that he had never told anybody about that had happened to him when he was ten and since then he's given up drinking and he doesn't take Seroquel which he was also prescribed by the psychiatrist which he doesn't even know why he was prescribed it because he's never been diagnosed with schizophrenia or any of the other things that apparently Seroquel treats. So I guess basically I'm just asking for more seeing mental health as a relational issue that can be addressed way before it gets out of control.

MS ABRAMSON: No, look, thank you very much. That was a very eloquent presentation.

MS ROSS: Thank you.

MS ABRAMSON: And thank you for your previous submission. We really would welcome another submission particularly about the examples you've given from overseas.

MS ROSS: Yes.

MS ABRAMSON: But thank you very much for sharing your experience and also having a very constructive view about what we could do so thank you very much.

MS ROSS: Thank you.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Thanks. Could I please ask the next participant, Ms Oakley-Lohm, I hope I've pronounced it properly. If you'd be kind enough to announce who you are and in what capacity you're appearing. Thank you.

MS OAKLEY-LOHM: Hi, I'm Jane Oakley-Lohm from Balancing of Life Counselling. Firstly, I'd just like to thank everybody; the Commission and yourself, Harvey and Julie, and the team for coming to little Launceston. It's much appreciated. Okay, a little bit about myself. It's quite diverse my background. I've been living in Tasmania for ten years but previously I lived in central Australia. So I do want to bring the attention to everybody in the room, including yourselves, the issues that are in central Australia and not just central Australia but rural and remote.

Having lived there in remote areas myself plus Alice Springs and working remote there is such a lack of service with today's mental health scheme. So I'm just going to give you a little bit

of an example. To begin with I guess my qualifications, if you would like to know, I am a counsellor, a clinical supervisor, a mediator, a project manager and assessor for trainee counsellors.

MS ABRAMSON: You're very busy by the sound of it.

MS OAKLEY-LOHM: Well, this is the past. In Tasmania we take a step back and breathe a little bit of the fresh air. The other thing that I have done in Tasmania has worked with long term unemployed people and I just want to - in a counselling role - and I just want to point out that for some people in Tasmania there is five generations of unemployed, that is a lot of issues with mental health. These people can't afford to go to a doctor, to get onto the mental health plan and then can't afford - if there is an out-of-pocket fee they can't afford it.

With the present mental health system there's many people that can't access the service and I just want to go over a few places. Farmers, they often have to travel at least one hour to get to a doctor. Doctors in small communities often have a wait time. Then there's an extra wait time to see a psychologist. Outback stations, they might travel five to nine hours to get to a small town and then of course they've got the same wait time. All these people that travel from an outback area to get into a town there is a cost. There's also no one to take their place on the station or the farm or the roadhouse or the Aboriginal community to replace them in their job so therefore they're pressured often not to go by their employer or their own self.

We have - don't forget all the tourist locations that are remote. How many employees are on the islands of Australia and Ayers Rock Resort et cetera et cetera, there's no way they can get easily to a doctor to get onto the mental health process. Rangers and their families live on remote areas, the same process there again. So I don't feel the system that we have today actually assists these people. Being a counsellor, and I do take onboard what you said before, sometimes we are looking at mental health the wrong way around. We're looking at, 'Let's provide a service for these people with extreme conditions here'. What about the people that are just coming through with issues, let's not get them to those extremes, let's help them now and I do feel there's a role for counsellors to do this.

Another example of how counsellors can help. I'll give you an example of what I did in central Australia. There is a lack of psychologists naturally and psychiatrists in Alice Springs and when we're talking Alice Springs mental health we're talking of the health region which is one million square kilometres. There's not many services out there and those people have to travel to get any help. So therefore the Mental Health Association of Central Australia actually saw this as a problem and contracted my business to come in and float with their clients more on a day to day system. So they could come in for a chat at any time and we would go through whatever was their issue for today.

Now, often they couldn't get in to see a psychiatrist maybe twice a year, once a year if they're lucky. Their psychologist a little bit more often but it was still extreme. Now, people with mental health issues can go up and down, up and down, up and down very quickly and go off medication, there's a crisis in their life. People in the outback areas don't necessarily have support from family and friends, they're isolated. So therefore what I'm saying is we need a system in place, and I feel this is the role for counsellors, that can help monitor them until they can get in to see a psychologist on the mental health program.

In Tasmania here on the north-west there's up to a four month waiting list to get in to see a psychologist on the mental health program. These people need help now. Yes, they still may need to get to the psychologist but let's give them some support which I feel counsellors can do to get them there. Because I'm so passionate about this and having now lived in central Australia for 30 years I've come away thinking, 'What else can I do?' I'd like to point out that today Telstra have provided a landline into all these areas; roadhouses, Aboriginal communities, stations, tourist complexes, they do have a landline.

So what I've started up with a group of counsellors from all over Australia is an online service. We're brand new, we have no funding and we now can provide a service seven days a week including out of hours. Some of our counsellors are providing a service till midnight and 1 am. There is a small cost involved because we don't have any assistance with this. We have kept the cost down because we are all working from home so at the moment people can access us between \$60-\$80. I do understand that with - and I'm not bagging out psychologists here, please don't get that opinion at all, we're all needed - some out-of-pocket expenses for psychologists today in Tasmania is up to \$80. There's a lot of people that can't afford that definitely.

We can take on, Balancing of Life Counsellors that does provide the service, we can take a client today but getting this information out to rural and remote areas is very difficult and I feel we need some assistance to do that. If there was some sort of support with counsellors being involved on the mental health scheme this would be fantastic. It would mean it would be a totally free service going out to rural and remote locations. And also in Australia in these big towns there's a lot of people with disabilities that their work career says, 'You don't have time to get off work to go see a counsellor', there's travel components, there's single families that can't get time out. They can put their kids into bed at night and can get on the phone to a counsellor at ten o'clock at night if they want.

PROF WHITEFORD: Sorry, can I just interrupt and ask the \$60-\$80 you mentioned, is that per session?

MS MARTIN-COLE: Per session, yes. It's an hour session.

PROF WHITEFORD: Yes.

MS MARTIN-COLE: The difference between us and an emergency service - an emergency service, for an example, Lifeline, a brilliant service, absolutely. They can talk to a client - it's around 30 minutes because it's an emergency line but that client can't pick up that phone again and talk to that same counsellor so therefore they need to repeat their story but with us they can pick up the phone and speak to that same counsellor.

I've done a quick research in the UK and I could be wrong but this is my understanding, that in the UK to access a psychologist they get a referral from the doctor. The community can access a counsellor without a referral and it's still covered by their mental health program, that's my understanding. That would be great to have here. So therefore the counsellors can help monitor the clients until they can get into the psychologists. If we're getting them early enough they may not all have to go to a psychologist. That has to help with funding all round.

The counsellors that are onboard with the Balancing of Life counselling are all Australian accredited, they're all insured and they all belong to a counselling body here in Australia which ensures they have ongoing training and supervision. Supervision at the moment is done by me so therefore if we are providing a service to rural and remote locations I do have 30 years' experience of helping them to deal with these people living in outback areas and if we do have this service going to outback areas we do need to have clinical supervisors that understand what's going on.

So I guess, (1) any questions? But (2), I do feel we have got a solution here. That can be picked up tomorrow. I can get heaps more counsellors onboard within a month to help provide this service. I was speaking to an Aboriginal counsellor only yesterday and she's from the east coast, she would also love to come onboard. You know, I feel can we take more onboard until we can get this word out, you know. I would love to see more central Australian Aboriginal counsellors come onboard.

And there is this opinion that Aboriginals must speak to an Aboriginal counsellor is, not necessarily true. Now, the reason for me saying this: I was employed some time ago to do a grief and loss project in the mental health region of central Australia. Now, that was run through Northern Territory government and La Trove University of Melbourne. Now, what I did in that project was to look at what is going on in central Australia. The amount of suicides is horrendous.

So I had to look at what is grief and loss for these people, do they have a tool, is that tool still accessible and if not what do they want? What I learnt from that is: (1) there's 26 language groups in central Australia of Aboriginals before you go into any other cultures. They all work through grief and loss differently. If we look at traditional cultures of the world they all talk about grief and loss openly. They never talk about depression. Our western community waits until we're all diagnosed with depression before we talk openly about grief and loss and I feel counsellors can help in that role. If we're not dealing with day to day grief and loss and giving them that support we're having compounding grief and loss which can turn into depression.

MS ABRAMSON: Harvey.

PROF WHITEFORD: No, I'm fine.

MS ABRAMSON: I just wanted to ask one question about your experience in Alice Springs and that is we were told there was a lack of coordination and integration between services and that was a big problem. I'm just wondering if you have any views on that and how it could be improved?

MS MARTIN-COLE: Okay, I haven't lived in Alice Springs for ten years but my passion definitely is still there. I can't give you the up to date details on that. At the time when I was there we definitely had meetings that you could attend but what you've got to understand when they have lack of services to begin with, for everyone to leave their job and go to these meetings about all the services there's no one behind here doing their job. They are bogged down.

So another project I did in central Australia was providing training or coordinating training to

all remote areas of central Australia in aged care centres and what we did - part of that project was to provide funding for people to leave their jobs so they could attend training and that is what's needed.

MS ABRAMSON: We've understood that point in the context of training or early childhood workers who have actually said one of the biggest issues is who does their job when they're attending (indistinct words).

MS MARTIN-COLE: Exactly.

MS ABRAMSON: Thank you very much for your presentation.

MS MARTIN-COLE: Okay, good.

MS ABRAMSON: We will have a short break until 10.50 at which time we'll resume and it looks like there's coffee and tea at the end of the room; is that right? Yes, the team are nodding. Thank you very much.

SHORT ADJOURNMENT

RESUMED

MS ABRAMSON: Thank you, we'll reconvene. We have on the phone, I hope that you can hear me, Diana Kube and, Diana, if you'd be good enough to announce who you are and in what capacity you're appearing. And we've got the mike here right for the transcript, that's the other thing if I could mention to people, the mikes are actually just for the transcript, they're not amplifying. Can you hear me, Diana?

MS KUBE: Yes, can you hear me, Lisa.

MS ABRAMSON: It's Julie, I can hear you. I'm not sure if other people in the room can but we'll do our best.

MS KUBE: Okay, I can speak up if you like. Is that better, Julie?

MS ABRAMSON: Yes, thanks.

MS KUBE: Okay, my name's Diana. I am a counsellor with postgraduate qualifications. I work in family violence and family and relationships counselling. I also do adjustment counselling for people with disability who have to adjust to disability in return to work programs. So I've been involved in the counselling space for a number of years and I am a bit concerned about some of the things I see happening including the corporatisation of the mental health space and the increasing devaluing of people with counselling qualifications in favour of people with social work and psychology qualifications where people with counselling qualifications are generally holders of postgraduate qualifications. Those are the issues that

I am finding a little bit disturbing because what happens is that as a counsellor I am unable to provide services that are covered by a mental health plan and by private health insurance. This is of concern because it increases demand on private psychologists who often have waiting lists of up to two or three months and are only able to see clients about once a month so it is a very changing space and I think that some of the changes are not as productive as they could be to ensure a high quality of mental health service provision.

MS ABRAMSON: Thank you. Look, I have to apologise for the people in the room, we've got the phone at maximum volume and I know it's very hard to hear. I'm just interested in your views, you said about counsellors providing more support which I understand from other arguments is about a Medicare rebate item but what are the other ways in which you think that the counselling workforce could be better utilised?

MS KUBE: I think many GPs overlook counsellors as a viable option when referring clients for counselling services. They tend to want to access psychologists whose skills are better utilised in other areas rather than general counselling so I think that that is an issue in itself. I also think that many not-for-profits are devaluing counselling staff in favour of employing psychologists and social workers where if you're wanting someone to provide counselling services why aren't you hiring a counsellor?

MS ABRAMSON: I'll just ask my colleague, Professor Whiteford, if he has any questions.

PROF WHITEFORD: Thanks, Diana. So you may or may not have seen the stepped care model that we have included in the draft report. On that continuum of care the role and the place for psychologists versus counsellors; is there an overlap or do you see there's more a discrete role for both within the stepped care approach?

MS KUBE: I think there's a distinct role for both. I think that when you're talking about delivery of services to specifically women perhaps impacted by domestic violence it may be better served by, you know, sending those people to a counsellor for a start. If you have someone with mental health issues that are significant, long term and ongoing then perhaps a psychologist or a psychiatric referral is more relevant to that person.

PROF WHITEFORD: Yes, okay, thank you.

MS ABRAMSON: I just had a general question about child and family support services and this morning we had some conversations about the lack of inpatient beds for adolescents so I'm just interested in your views on how that adolescent mental health is being provided in Tasmania particularly with headspace if you're able to comment.

MS KUBE: I think headspace provide an excellent service. Unfortunately I think they are not able to provide the range of services that I think they would like to have and that they are not able to provide the intensity of service that they would like to. In Tasmania we do have a really significant issue with lack of mental health inpatient facilities for adolescents and these children are often having to go interstate for services where their families can't be with them and that in itself is a strain on someone with a mental health problem. I've had many clients whose parents have, you know, given up on trying to access inpatient services here and gone interstate for service and it's often complicated the issue rather than solved it.

MS ABRAMSON: Can I also ask you a question: if the view is that GPs and NGOs undervalue counsellors, what more could we do to promote the value of counsellors?

MS KUBE: I think part of that is ensuring that they can be registered to provide private health fund services so services that are covered by private health insurance and a mental health plan so that people don't feel that they have to pay a huge amount of money upfront but it also demonstrates that counsellors are valued by the community and the government.

MS ABRAMSON: One of the other things that we're being told is that GPs getting info back on services about a client has increased their appreciation of the value of services and we certainly heard that this morning in terms of the psychologist working with GPs who were initially not being particularly supportive so to what extent do counsellors provide information back to GPs when they're the referrer?

MS KUBE: The referrer, we also seek - well, I specifically always seek the client's consent to report back to the GP but I do like to provide a service that is a holistic service so that GPs, schools and other key stakeholders are involved but I can only do that at the discretion of the client.

MS ABRAMSON: Harvey?

PROF WHITEFORD: No, that's fine.

MS ABRAMSON: Thank you very much. I'm sorry that the technology hasn't been as great as we'd hoped for but thanks for persevering with us and for making the time, thanks very much.

MS KUBE: Thank you.

MS ABRAMSON: I do apologise for that. Now, our next person we have is Mr Asten. If you'd be kind enough to state your name and the capacity in which you appear. And I also invite you to make an opening statement should you wish to do so.

MR ASTEN: Thank you. Yes, I would please. Is that in the right place? Is that okay?

MS ABRAMSON: He comes and moves it if it isn't, he's pretty - - -

MR ASTEN: Good, thank you. My name is David Asten. I live in New Town, Tasmania. I'm here to put my concerns to the Productivity Commissioners and thank you for the opportunity of coming along. I've got three key points in support of a national database of mental health orders. Now, mental health orders as you'll be aware are not for the everyday mental health patient but for those with severe mental illness who need some support, some direction, some - yes, support and direction not necessarily that they volunteer for.

So three key points. A case study that I'm very familiar with; personal experience of something else that's possible; and a plea for leadership and improvement in mental health administration between the states and territories of Australia. Now, the phone rang years ago and I stirred. It

was 1:30 in the morning. My wife grumbled. It wasn't a nuisance call but a call that was to highlight a shameful gap in Australia's legal systems concerning mental health, a shameful gap in Australia's ability to look after its own.

There is plenty of publicity for the boat people and others that come to Australian shores looking for refuge but there's very little action or publicity for those Australians with severe mental illness. And thirdly, a shameful gap between the Australian states in how they manage mental illness and that gap constitutes neglect in many instances and then allows for abuse of Australian citizens with mental illnesses.

So let me go back to that phone call at 1:30 in the morning. Our loved one needed money to pay the taxi driver and my question was, 'Oh, whereabouts are you?', 'Oh, I'm in St Kilda', 'Oh I thought you were at the Royal Hobart Hospital?', 'No, I'm sick of that place. I needed to get out'. And that was the start of a bit of a story about how our loved one had managed to get through a locked door and escape as it were and eventually a day later turned up in Melbourne and it's really the start of a story and an example of neglect between states and the potential for abuse then because as you'll hear shortly in Hobart I rang the Royal Hobart Hospital and those in charge of the psychiatric ward said, 'Oh, thank you for letting me know. We'll cancel the mental health order. Good luck'.

I rang the mental health administration, 'No, can't follow-up, she's outside our jurisdiction' and because this particular person I'd corresponded with often he said very quietly, 'My manager would cane me if I rang Victoria about this and I've got a heap of jobs on my desk that I'm yet to attend to'. For our family there were then followed two visits to Melbourne to catch up with our loved one because for better or for worse she kept ringing us because she was short of money and when we met she was under the close supervision of the manager of a half star boarding house in St Kilda and the manager said, 'She needs more money'.

I went to the Victorian Police, 'No record of your loved one here, she's over 18, low priority for us'. Went to the mental health department for Victoria, 'No records here, no reason to check up' and my impression was that the person concerned thought parents were fussing too much about an adult child. We kept on trying to do what we could and two months later I managed to talk to a young constable in the St Kilda Police Station and she listened and not long afterwards our loved one was transferred to St Vincent's Hospital. Now, with two months of neglect her state of health was most unwell and it took two months in hospital of intensive treatment to restore the balance and be ready for discharge but then St Vincent's Hospital said, 'We haven't anywhere to send her. What are you going to do?' So there were more phone calls for me in Hobart and eventually I got through to a deputy secretary for health and I went to see this person and she conceded rather reluctantly that this person was Tasmanian, we ought to take her back.

The followed prolonged but volatile time in the Royal Hobart Hospital the mental health order was renewed, our loved one had time in the psychiatric intensive care unit, even time in the forensic mental health unit and today I'm very happy to say our loved one's a different and lovable person because she has medical supervision and medication taken each day and it makes a world of difference. But it's not only a world of difference for her and for us as family, it's a very big change for the mental health staff, even the police, because at the moment as back then when someone becomes ill in the community the police are involved and the police

can't leave this person until the hospital take charge.

Now, the Royal Hobart Hospital and the Launceston General Hospital have got queues of ambulances waiting and so people with mental illnesses don't get - because they haven't got a broken leg, they haven't had a heart attack or a stroke, they don't get first cab off the rank in the hospital and so the police are tied up for a considerable time. It's been reported in Hobart that the police can be there for four/six even eight hours waiting for their client - their person to be admitted and looked after appropriately in A&E so here I see a great potential for productivity improvement and that can come about because if states cooperate with each other and recognise for instance that a mental health order in Tasmania should get the same priority as a mental health order in Victoria and vice versa.

Now, I said earlier that I had a second point about personal experience and it goes back a few years and it concerns a family wedding. Now, that might sound strange in this context but my wife and I stayed overnight in Melbourne because the wedding was up near Albury. I left the hotel next day, I drove up one of the Melbourne streets and I got in the wrong lane and while I manoeuvred back into where I needed to go the lights flashed behind me and the young traffic policeman wanted to ask me what I was up to. My driver's licence was taken away for a few minutes and he came back and he said, 'Mr Asten, I see you had a speeding fine three years ago and a couple of minor incidents in earlier years. You're here for a family wedding? Well, take care, respect our road rules and enjoy your holiday'.

And there was a system that makes state-based drivers licence records available to every police force in the country. Why can't we have something similar for mental health orders? What's the matter where they are senior clinicians and senior public servants that they can't see that there is scope for a great productivity improvement if those systems are recognised between states? Because I know from experience and I know from talking with others that prolonged time without treatment for a person with mental illness means a long time to recovery, sometimes prolonged damage. So there is every reason in the world for Australia to bang a few public servant heads together and say, 'Get this right between states'.

Now, my recommendation is that there be a national database for mental health orders. A database like the drivers licence one is accessible to every police force in the state, accessible to all the major hospitals and that improvement in productivity will please the treasurers in each state but that's only half because what's really important is that the person concerned will not suffer the same level of illness and prolonged disability that goes with this type of mental illness and their families will benefit, their friends will benefit, the community will benefit, even the police force will applause if they don't have to stay with patients who need immediate help because they've been without treatment for so long. And so for that leadership is needed. It's needed a combination of law, a combination of health and police with of course the cooperation of the state treasurers but the treasurers will benefit and I can't see why when after all these years why our political leaders don't see the value of harmonising mental health laws and treatment protocols.

MS ABRAMSON: I'm going to respond a little bit to that before you get to your next point. It's a really important point that you've made. I mean, I'll be honest, I haven't really thought about that. The only possible answer is because the Mental Health Acts are all state in nature they've all got different quirks and are slightly different but it seems to me there are two issues

in what you're talking about. The first one is an action of national register around actual orders made by mental health tribunals. The second issue we're having another look at is the data right or a consumer right to their own records and My Health Record, as far as I'm aware, Harvey, is a national-based service. It may not be as supportive for you as family, your access to those things, but it's a really important point. I don't know if you know much about the mental health orders and whether they're recognised interstate, Harvey?

PROF WHITEFORD: So the orders are supposed to have transferral capacity so that if you need to be transferred from one state to another you could be transferred seamlessly under the different jurisdictional orders but your point is if you were under an order in one state and you turn you up in another state, as your loved one did, there's be no way at present of knowing that person had been under the Act and that sharing of information, I guess if we have to jump through the privacy hurdles, but I suppose your point would be if it's there for road traffic offences, perhaps something more important about protecting lives.

MS ABRAMSON: It's interesting, we will all have a very good look at that because I even think that the fact that it is a public record might mean that some of the privacy concerns have already been dealt with. We'll have a look at it, it's a really important point.

MR ASTEN: Good.

MS ABRAMSON: And I interrupted you, you were going to make another point to us.

MR ASTEN: No, I'd come to the end of my prepared part but I'd be - I mean, you talked about people in the past and I think back to Cornelia Rau. Now, Cornelia Rau was a resident - in fact she was a Qantas air hostess about 15 years ago, became unwell, moved from Sydney to Queensland, became even less well, and was arrested by the police and because perhaps of her family background she was thought to be an illegal immigrant and she ended up being put in a detention centre in South Australia and it was quite some time before a regular visitor was a bit puzzled and started to ask questions and dig and it was found she was an Australian resident. Yes, with a bit of an accent as there are many people in Australia and if you look at her website you'll see that not everything has gone right for her since but an example of the kinds of things that happen when people go interstate and there are very few that have publicity because of the contacts that I have, family shy away from exposing their loved ones to the public eye.

MS ABRAMSON: But the corollary answer to that is when you're talking about the licence, there are very strict protocols around police as to who can access what on a public database so those are things that - I mean, I'm just thinking out loud - you could build the right type of protections in them.

MR ASTEN: If drivers licences can be accessible to every police station in the country then surely there would be a - the police would have some protocols for certain categories of Australian citizens. For instance, I'm quite sure that there would be a special register for federal politicians. They would be dealt differently from me probably in a number of respects.

MS ABRAMSON: No, it's a really important point, we'll have another look at this. Could I ask you a different question which is being in Tasmania how easy is it to access services in other states?

MR ASTEN: We've not tried to access services in other states. We have taken our loved one on a holiday to Queensland in the intervening period but we sought that out with the Tasmanian authorities and we undertake to supervise the medication.

MS ABRAMSON: Thank you. Harvey?

PROF WHITEFORD: No, that's fine.

MS ABRAMSON: Look, that's been a really important - I mean, all of the evidence matters but this is something that we'll have a really good look at and I know you've travelled today to be with us so thank you very much for that, thank you.

MR ASTEN: That's fine. It's important not just for us but I suspect if there are 25-30 Tasmanians that escape their mental health orders each year that would be equivalent to 1000 or more across Australia, maybe 2000 and I'd ask if you don't have that statistic I'd suggest you ask the states to present that information.

MS ABRAMSON: We may have a lot of trouble getting data but what I can say we will have a look at - is because this will not be a novel problem, although it feels like it I'm sure when you've experienced, there will be a reason why - someone will have suggested this and there'll be a reason why it hasn't happened so we need to have a good hard look at that. Thank you.

MR ASTEN: Thank you.

MS ABRAMSON: Could I please ask our next participants, Ms Jones and Mr Jones from Tasmanian Life Counselling. If you'd be kind enough to state your names and also the capacity in which you appear. I was about to make the assumption which may not be accurate.

MR JONES: No, it would have been accurate. Not a problem at all.

MS ABRAMSON: Thank you.

MR JONES: So my name is David Jones. I am currently working again at a couple of different places one of which is a drug rehabilitation centre but my role here today is to really express for the case why I think counsellors should be recognised in the same way as psychologists and - well, psychologists particularly in the counselling field. Part of my experience sort of stems from - did you want to go first (indistinct words). Okay, I'll keep going. One of the first things I was taught when I transitioned from industry into counselling as a professional probably five/six years ago now was that one of the things that counsellors do is look for incongruity in the client's story and what's happening so we can actually identify where we might work with them and one of the most obvious incongruences in this industry was the fact that the counsellors as a profession aren't recognised with similar qualifications and skills as psychologists and it was like how does this even - how does it work? How does this happen? We have the same qualifications, we do a four year bachelor's degree and since then I've actually gone to try to do a Master's of Social Work degree but I've actually found it doesn't actually compound or enhance my capacity as a counsellor to operate so I'm working through it mainly so I can actually be part of the MBS process so I can actually deliver the

services that I believe are necessary here in Tasmania.

In that journey over the last four or five years I've actually worked for a couple of organisations that provided men's behaviour change programs and I've identified there's been a number of weaknesses in those areas and a number of strengths in those areas but what I've identified and most particular is we have an insufficient capacity to actually reach the majority of Tasmanians. We have a couple of programs that work out of Launceston, a couple work out of Hobart and some have worked out of Burnie but we may reach between those programs maybe two/three hundred medium to low or high risk family violence offenders in that group.

Within those groups of the guys that tend to attend those programs, you have a (indistinct) rate at probably more than 50 per cent in the first few weeks but probably what's most prominent is the fact that those that live in geographically remote areas such as St Helens or - well, pretty much anywhere that's outside the normal capital cities there's an incapacity to those individuals who often lose their licences for various reasons, there are other maybe life factors that affect their capacity to actually attend so you see a very poor take up of the service but also a very poor capacity for them to be actually benefit from the psychoeducational programs there are.

As a personal frustration for me both in that the Tasmanian counselling service and also in general is that the incapacity that I've had to actually being able to get out and actually service that market, there are very few individuals that I've come across (indistinct words) few that I've come across that actually have interest in the actual dealing with the offender side of the problem. Lots of victim services (indistinct words) work but for me prevention is actually a better tactic than cure but I believe that there is a much greater capacity for that psychoeducation program to be taken to regional centres but often funding becomes a part of that problem so I believe that if there were more counsellors available (indistinct words) to offer those kind of psychoeducational services (indistinct words) MBS process - that is, programs could actually work to combat that problem directly.

So I think that is the majority of my argument. It's men support in general is actually quite poor and I think the men that I've worked with tend to have a perception, accurate or inaccurate, that there's a kind of a scaling process that happens associated with the level of stigma that you'll be labelled with from your mates depending on the kind of service that you actually apply to so if you apply to a counsellor, that could be anything (indistinct words) problems, relationship issues, not mental health issues per se, just struggling with how to cope and actually manage day to day activities. At the moment you are actually directed towards a psychologist, which is maybe the only service that's available, you've instantly escalated then to, 'Well, I'm actually going to see a shrink' or 'I'm going to see somebody who is directly interested me having a mental health issue' and as soon as I'm labelled with a mental health issue then less likely again (indistinct words) process and if you get to the level of a psychiatrist then you're really in trouble because, you know, you're really off the deep end somewhere so whether it's accurate or an inaccurate perception I think that general stigma is still prevalent and men particular - more are accessing general health services so mental health service is an even greater struggle and I believe that giving the capacity to counsellors in those regional areas where there is more familiarity with (indistinct words) as part of the community. They're flexible, they're more local, they're easier to access, I think it makes a likelihood that they have an interest in attending a service or attending some support, it's likely to increase with locality and geographical support in mental health.

MS ABRAMSON: Can I - thank you, can I - we're well aware of the point that the counsellors have made but I'm really interested in the comments you made about psychoeducation programs; what do they look like?

MR JONES: Well, a psychoeducational program is something that actually attempts to breakdown what are essentially taken for granted activities like relationship issues might be a fundamental one and a psychoeducational program might be a three or four week program which includes things like the quality, it may include behaviour towards each other, interpersonal communication, a whole range of things which enhance that person's education skills and (indistinct words) understand what's happening around them, understanding emotion regulation so it increases their capacity to understand who they are and how they interact with other people and it's purely educational - - -

MS ABRAMSON: Is it being done mainly in schools or is it broader than that?

MR JONES: No, the Men's Behaviour Change Program is actually at a high proportion of education (indistinct words) as long as ten weeks and, yes, it's actually - there are some that are court mandated, there's a couple of court - - -

MS ABRAMSON: Yes, I'm really interested in hearing a bit more about the forensic side of it because I can imagine as part of an order that people are mandated to do this course and then the difficulty is, especially if you're in rural and regional Australia, where is the course actually being run and you very eloquently said it could be difficult to get there so I'm just interested in how much of those type of programs you do?

MR JONES: Well, I'd like to do a lot more.

MS ABRAMSON: Yes, yes.

MR JONES: But as I no longer, and this is perhaps one of the issues here, is I no longer work for either of the organisations, one of which I helped design the program and the other one which they have a program that's already in place. Whilst I was working for those organisations I was qualified to be able to deliver the program and even create the program. On needing those programs - - -

MS ABRAMSON: Were they supported by the health department or justice or?

MR JONES: Part of the Safe Home, Safe Families - - -

MS ABRAMSON: Okay, that was a Tasmanian program?

MR JONES: Yes, Tasmanian program, two Tasmanian programs.

MS ABRAMSON: Yes.

MR JONES: But you're absolutely right in terms of the family violence offender intervention program which is a mandated program from the courts for the medium to high risk offender,

you may start with 15 people of which some may be from regional areas because they've got a lift in or they've got something to do - - -

MS ABRAMSON: So it's done as a group therapy type - - -

MR JONES: It's a group therapy environment. But often you would end up with individuals not completing that mandatory aspect of their order, their 12 months would expire and they've never actually attended even a single session simply because it isn't possible for them to get to the program itself and there's a kind of little bit of a (indistinct words) attitude towards that saying, 'What can we do without taking a bus out there to collect them?' The bus services from regional Tasmania are quite notoriously poor in terms of their timing so finding the flexibility to deliver those courses where they are - I mean, I'm sure it's been considered but certainly there's this attitude, 'Well, look, they just kind of fall between the cracks' never having (indistinct words) and we haven't really served the public interest in terms of protecting the individuals or enhancing the safety of these individuals (indistinct) they may have impacted against (indistinct) so there's a big huge gap that - - -

MS ABRAMSON: Thank you. Harvey?

PROF WHITEFORD: Sally, did you want to?

MS JONES: Yes, I've got a different angle.

PROF WHITEFORD: Okay, let's give you a chance.

MS JONES: Thanks. I'm also a qualified counsellor with over 20 years' experience. I've all university degrees and a PhD candidate at the moment and I find it quite frustrating with my experience that I'm not recognised as a mental health professional and quite frequently come up against the barrier of, you know, 'Are you a social worker?', 'Are you a mental health nurse?', 'Are you a psychologist?' Well, I do the same work and I've got enough experience and academic qualifications to say I'm quite capable of doing the work yet just not recognised.

I've done a lot of work in rural remote areas of Tasmania on the east coast and north coast of Tasmania. I've worked closely with GPs and now that I've left a psych practice I was employed as a counsellor under and gone into private practice the GPs are happy to continue working with me if I've got a provider number and I can't get that. You know, I've rung the Medicare line and said, you know, 'What does it take?' and pretty much, nah. I even have an AHPRA registration number because I'm also a qualified paramedic but I just can't get that recognition so it's a shame that the GPs won't refer to counsellors. You know, we really need to push that a little bit more and I've done some work just talking to GP groups at their practice to try and get them to understand our profession a little bit more so that - in their heads I think they just think their only option is to refer to a social worker or a psychologist - - -

PROF WHITEFORD: Sorry, can I just clarify that point. So do you think that is about the fact that their patient can go get a rebate or is that they didn't believe the counsellor could provide the treatment or the intervention that they believed their patient needed?

MS JONES: In my case because I've worked with the GPs they know I can provide the

service; it's the rebate. And particularly in the remote areas there's a lot of employment issues in remote areas of Tasmania and that's a lot of the presenting issues that they come to counselling for is housing, employment issues particularly those - like, I've had a 60 year old ex-tradesman come to me saying he's just at the end of his tether because he's been asked to go by on Newstart, is his only source of income, he's been asked to go and look for jobs and he's riddled with arthritis and he can't get these jobs so he's experiencing depression, anxiety and suicidal ideation.

PROF WHITEFORD: Sorry to keep interrupting. I know that you've probably got a script that you want to follow but I guess the challenge is between - you know, what you were saying there and what we've just heard from David about at one level the advantage of counselling is that it's not part of the mental health system, it's not connected to the mental health items on the medical benefit schedule, it's not medical, it's not clinical in the sense and so therefore it's less stigmatised perhaps and might be more accessible but on the other hand you need to get in there because there's no other - if I'm correct, no other source of financial support to do the counselling work; is that the right balance as I'm describing it or?

MR JONES: Yes, I think to me there is a link there in the fact that that's - because often - because of the poor job provision and everything else is that there's a sense there that these individuals don't have the capacity to pay quite often and their only source of being able to get access to services is through the Medicare Benefits Scheme so it's almost like they're happy with a mental health plan - - -

PROF WHITEFORD: But do you think that's the right thing? Like, would that be the right way to remunerate counsellors or should there be a different way of remunerating them so that they're not marked out as part of the MBS mental health - you know, - - -

MS JONES: We could apply for funding to support particular programs and Primary Health Tasmania do offer funding for short term psychological intervention which is a program that I had been working under at the psych practice that I was employed under but now I've gone into private practice, if I contact Primary Health and say, 'Can I also get that funding to continue to provide services?' one of the first questions I'm asked is, 'Are you a social worker? Are you a mental health nurse? Are you a psychologist?'

PROF WHITEFORD: So they would let you do that when you were part of the contract that they commissioned - like, the commissioned work, but that people outside of that contract aren't able to be supported to do that work?

MS JONES: In my experience. I don't know whether others have had better luck with it but in my experience, you know, because I worked with a psych practice and it was the psych practice that got the contract so now I've got a counselling practice I can't get one and there's so many people out in those remote areas that need services and there's like a four to six month waiting list to get in to see someone. We've got a pool of counsellors that could fill that gap but we're just not recognised.

PROF WHITEFORD: Okay, sorry for interrupting. Sorry, I'll let you finish off what you have started.

MS JONES: And we also see suicide rates increasing here in Tasmania particular amongst the male population. My other professional is a paramedic and I have seen people at the extreme end of their mental health where they've just got so frustrated with the system and not being able to get support and, you know, if you've got suicidal ideation you can't be waiting four months to get in to see someone so they really need to have a greater availability of resources and we've got it right here under our nose and I just don't understand why degree qualified people are not able to come onboard and offer these services and we're just not recognised. I mean, it's ridiculous. Mental health is just going through the roof. The health system is in crisis and we've got something right here, a resource that can help with that and just not recognised.

MS ABRAMSON: Do you have a view about the type of counsellors that will be providing the service because we know, for example, with psychologists that we got given some evidence this morning that they all have a basic training in particular things but may not specialise in it so when you think about the counselling group do you have a view of exactly which counsellors would be the ones that would be authorised to provide the service?

MS JONES: Well, I think under the Australian Counselling Association, level 3 and level 4 memberships would be appropriate because they are degree qualified. Not everyone needs to go to that level of membership and that's their choice but, you know, to be a level 3 - or I'm a level 4 member and that's - - -

MS ABRAMSON: What's involved in that?

MS JONES: I need to be degree qualified, have a minimum of six years post-qualification counselling experience including 1000 client contact hours and complete 100 hours of professional supervision so professional supervision (indistinct words) ethical and legal practice.

PROF WHITEFORD: Sorry, outcome measurement is something that's come up repeatedly with assessing the interventions provided by a range of psychological service providers; is there any collection of outcomes in the way that the counsellors practice in your experience?

MR JONES: Is that question directed towards are there any items like such as a K10 or - - -

PROF WHITEFORD: Yes, something like that.

MR JONES: Okay. Yes, it's actually a difficult - because you're not actually measuring an improvement in someone's mental health per se, what you're actually doing is perhaps observing a change in the quality of their life and their capacity to address day to day situations such as grief and loss, something that's - you know, somebody passes and you're not quite sure how you feel about that so you're really just talking to somebody (indistinct) you may be able to identify through something like grief therapy within three or four weeks and they seem to have come to terms with their part in that, how they feel about it, whether they want to move forward from that so there's unlikely to be a measurement or what you might see is a change in that person's urgency of demand for support in that space.

PROF WHITEFORD: So a different way of measuring it such as their reflection of their

quality of life or their wellbeing rather than the clinician (indistinct words) 'Do you have these symptoms?' sort of thing, is that what you're saying?

MR JONES: That's right, yes, yes.

MS JONES: And there is a quality of life measurement tool that we can use as well and the K10 is what we use in our practice and that's useful for the client as well because sometimes - like, we'll re-assess that after six sessions and they might get to that sixth session and thought, 'Oh, I haven't really improved' but you can actually show them you have and you can show them areas in which they've improved so it's quite a useful tool and it's good feedback to the GPs as well so we always (indistinct words) - - -

PROF WHITEFORD: Yes, so I guess that's another question we often ask because part of the concern we've heard expressed about the system is it's too many silos and not enough connectivity between the different provider groups and so your experience working with GPs or other providers?

MS JONES: Yes, I've worked closely with GPs but now I'm in private practice I'm not getting as many GP referrals because they are referring to the psychologists or people with provider numbers and that can be the social workers as well. Again, it's about keep on pushing that wheelbarrow to educate them and say, 'Not everyone needs to be on a mental health plan and not everyone needs to have the rebate' so some people can afford to be fee paying and it's just about making it an affordable rate. It's a bit like public versus private health insurance, you know, if we overload the public system with people that could afford to go private then it increases that burden so we need to educate the GPs as well to say, 'There is a percentage that needs a rebate so let's reserve that for those people and the others can be fee paying'.

MS ABRAMSON: If you've got any data on outcomes we'd be really interested in seeing that, that would be really helpful.

MS JONES: Yes, sure, yes.

MS ABRAMSON: But thank you very much, that was really helpful.

PROF WHITEFORD: Yes, thank you.

MS JONES: Thank you.

MS ABRAMSON: And the next person, can I welcome Mr Blair back to the Commission. If you'd be kind enough to state your name and your capacity in which you appear.

MR BLAIR: My name is Michael Blair and, yes, I'm here in a different capacity today representing the Australian College of Mental Health Nurses not as an individual where I was previously. The Australian College of Mental Health Nurses is the pre-eminent authority voice of the mental health nursing profession in Australia. It provides leadership and advocacy for mental health issues across the mental health sector in nursing and it sets national standards of practice in mental health nursing.

The College's initial submission to the Productivity Commission into mental health called for a more comprehensive insightful response to workforce issues in mental health. The College members and the board of directors acknowledge the work done by the Productivity Commission and calls on governments, both state and federal, to recognise the merits of the recommendations below and implement those recommendations. In particular we'd like to make comment on a couple of the recommendations. The first being a request for information under 7.1, freeing up psychiatrists for people who need them the most. Your question is what additional steps, if any, should be taken to support private psychiatrists to increase the number of consultations involving new patients? Our comment is that specialist mental health nurses have worked for many years alongside and in collaboration with psychiatrists and trainees in the private and public sector and this should be promoted as one way in which we can free up psychiatrists for people who need it the most.

The triage and counselling should not be seen as contrary or in competition to psychiatrists but work in synergy with psychiatrists in providing the care. The specialist mental health nurses also work in GP practice and have assisted GPs with persons with complex mental health issues and the accreditation practice standards for mental health that are developed by the College for nurses working with GPs has progressed and is available for evidence and this was completed as a project by some of my colleagues, (indistinct words) and I'll provide that reference. To enable this work to further occur, we will need to ensure that funding is targeted to the MBS line items for this work and compensation services is made available for the infrastructure and office needs et cetera.

In relation to draft recommendation 11.1 we would like to make comment on the mental health workforce issues divided between rural, regional and remote workforce. Targets need to be specific in addressing location as we roll out a whole of country workforce strategy. We cannot neglect our rural, remote regional areas of need.

We would also like to make reference to your recommendations in 11.3, which are more specialist mental health nurses. Initially the first recommendation would be that, as stated in your recommendations, accreditation standards should be developed for a three year direct entry degree in mental health nursing. We fully support that recommendation and believe that the recommendation should be implemented now rather than later. The two to five year recommendation timeframe was seen as being not adequate in the fact that we are really facing crisis at our present time.

Merits of introducing a specialist registration system for nurses with advanced qualifications in mental health; we also agree with that wholeheartedly and we'd also make recommendation that this should be enacted in the short-term, not the long-term.

We would also request that credential in mental health nurses be a stamp that is recognised by the profession to ensure ongoing professional development is maintained and clinical supervision provided to clinicians working in mental health as these standards are afforded to other allied health and medical colleagues, but not considered mandatory in nursing. It should be noted that many mental health nurse academics have also expressed enthusiasm online in work creating a curriculum that complies with the recommendation made for direct entry undergraduate entry. So that's promising.

We would ask that the mental health nurse incentive program be reintroduced and access to MBS line items made available to credentialled mental health nurses and this will ensure that other alternative options of treatment are available to consumers in the community as a component of their mental health plan.

And, finally, in relation to your information request under 19.2; personal care days for mental health, we would make comment that there is recently introduced 'mental wellness benefits' introduced by some of the larger companies in America and have allocated additional leave of 10 free wellness counselling sessions to all employees, and we believe that this would be of merit and that these would be in addition to what is currently offered as EAP.

And, finally, just in relation to Mr Asten's comments; I'm not sure he's still here but - - -

MS ABRAMSON: Yes, the mental (indistinct).

MR BLAIR: Previously I've mentioned the need for a national mental health act and I think that it was interesting that Mr Asten was calling for better coordination between state jurisdictions in relation to mental health orders. I think the national mental health act would be one option that would overcome that barrier and we acknowledge that there are a brand of understanding between the states and there's a lot of money put into ensuring that people don't fall through gaps. But certainly my experience and Mr Asten's experience is that that still does occur and that we need to address that.

MS ABRAMSON: Thank you (indistinct).

PROF WHITEFORD: Right, so just going back to the issue about undergraduate entry. So we understand that a curriculum was developed or has been developed.

MR BLAIR: Has; it needs to be updated.

PROF WHITEFORD: Sure.

MR BLAIR: I think it was taken offline - I don't quite remember, but I think it was late (indistinct).

MS ABRAMSON: You're on the transcript.

PROF WHITEFORD: That's why he said that.

MR BLAIR: Yes, and my memory's not so (indistinct), but it is still available and a lot of people have expressed interest recently since your recommendation that they would like to be involved in a collaborative effort to redevelop that curriculum.

PROF WHITEFORD: But from the perspective of the College of Mental Health Nurses which you're here representing today, that college is behind the recommendation.

MR BLAIR: Yes.

PROF WHITEFORD: And mental health nursing in regional and remote areas of Australia; a big challenge.

MR BLAIR: Yes.

PROF WHITEFORD: Any specific comments about how we can improve in that space?

MR BLAIR: Well, having worked and developed community health servicing in both Hopevale and Yarrabah in North Queensland, the issues that were discussed today about the stigma are very relevant when it comes to Indigenous mental health. The types of infrastructure and design of those health services was very aware of those issues and we put in place, you know - the discussion today about the west coast of Tasmania and how people would go from one town to another town in preference to being seen in their own town; it's the same in North Queensland, has the same issues. If you're seen walking into the health centre and you're going to see the psychiatrist who happens to be a fly-in, fly-out then, everybody in the community knows.

So we, through our architects, developed a method whereby the clinician would enter from a rear door, the client would be seen to enter from the front door. So I mean from a safety perspective it was good because there were two doors to the consulting room, but nobody could actually see who they were going to see and those rooms were used generically. So they were used as well, you know, by the dietician and the psychiatrist and the GP or whoever was visiting, and that got around that issue.

But then, there were issues about men's health and women's health; very separate and we had areas that were co-located but separate within the community health service. But mental health nurses; I hope that we'll be hearing from the Royal Flying Doctors Service this afternoon.

MS ABRAMSON: Yes, they're on this afternoon.

MR BLAIR: I have colleagues that work within the Flying Doctors service and provide that fly-in, fly-out service. Issues of clinical supervision for them are very relevant and very important and that's one of the things that, we say, is something that needs to be addressed is that, you know, you can't work as a sole practitioner without that supervision, without that reference point to, you know, get feedback on your practice.

MS ABRAMSON: Mr Blair, can I ask you about stigma within the profession - and we might've discussed this with you before.

MR BLAIR: Yes.

MS ABRAMSON: Sort of the activities that the college is undertaking to make it a more attractive proposition for people to take up mental health nursing, and you started to talk about that I think.

MR BLAIR: Yes, look, I've read the Health Community Services Union report to the Productivity Commission and/or it might've been to the Victorian Commission.

MS ABRAMSON: It might've been the Royal Commission, yes.

MR BLAIR: But they have a per capita report which is the first report that I've seen where there's been measures and a survey done of the number of mental health nurses with lived experience and be that as a carer, be that as having cared for a friend or be that as an individual with a mental illness, themselves, and it was interesting that this is the first time that that has ever been done within a health profession.

I think we talk a lot about lived experience, but there is lived experience within our professions and if we were to do more about identifying and bringing that out of the closet, I think we would address a lot of the stigma within the profession and that's probably the first time that I've seen it actually researched and identified and it's a whole new opportunity that needs to be unwrapped.

MS ABRAMSON: Well, thank you for drawing that to our attention, today. Thank you very much.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Could I, please, ask our next participant, Connie - I may pronounce this wrong - Digolis from the Mental Health Council of Tasmania. If you would be kind enough to announce your name for the transcript and where you're from, thank you.

MS DIGOLIS: It's Connie Digolis.

MS ABRAMSON: Digolis.

MS DIGOLIS: From the Mental Health Council of Tasmania. I'm the CEO there.

MS ABRAMSON: And I'm assuming you have an opening statement that you'd like to make.

MS DIGOLIS: So, firstly, we'd like to acknowledge and thank the commissioners for their consideration of our formal submission to the inquiry in May this year, and acknowledge the breadth of the draft report and appreciate the multiple opportunities that you're actually offering ourselves and others to provide input and feedback into the final report.

Our role as the peak body for community managed mental health services is to provide an independent systemic view while also ensuring that we're advocating for better mental health outcomes for all Tasmanians. In regards to the draft report, and while we're preparing our submission to lodge in January, we've looked at, and are happy to provide some additional feedback, around the structural reforms and governance.

We welcome the considerations on addressing continuity of care within structural reforms and the need for intergovernmental agreement and the challenges that we currently have and that need to be addressed in regards to roles and responsibilities across all tiers of government. But we do wonder how we can ensure that that can be implemented successfully that was always in the detail.

We also have looked closely at the mental health and wellbeing in the schools area of the report and, while we applaud the recognition of the importance of perinatal and infant mental health and wellbeing, we'd also like to point out that we feel that there still may be some gaps. There's some great acknowledgement there around a whole of life and a lifespan approach, but we think there's more that we could be looking at in the primary school and especially in the high school areas as well, and actually looking at, for our high schools, looking towards less of a clinical-based and more of a strength-based approach and building skills and resilience within high school students themselves and looking at peer support models which are proving to be very successful.

We also have noted the national mental health workforce strategy and, while we acknowledge it's important to ensure that all existing and planned state and regional mental health workforce strategies are there. We've also got the regional planning that's actually happening, so we're wondering about the relationship between a national workforce strategy and the state and regional strategies and plans that we know are either in train or actually already exist. So we'd like to see more detail in how those various levels all actually talk to each other so we're not undoing the work or some of the directions that have already been set.

MS ABRAMSON: Thank you. The second bit, I might ask my colleague to speak to that around the workforce strategy and regional planning because we're very open to ideas which is part of the reason our models that we put out were for discussion, particularly around the RCAs. But are you happy to give some questions about the workforce (indistinct).

PROF WHITEFORD: Yes, so obviously it's a distributional issue and the development has been about national workforce model and that assumed then, that you've got a sufficient number of people estimated for Australia then, distribution of those across urban, regional, rural areas, even within states that have enough people is the challenge.

So there are methods that have, I guess, been applied to try and even out that distribution. Are you aware of anything that's specifically worked in Tasmania where they've tried to get services outside of major urban centres?

MS DIGOLIS: No, and certainly we've had discussion around incentivising and being able to setup partnerships with universities to be able to look at internships and incentivise graduating students to actually do some time in the rural and remote areas. But we've actually got shortages across the entire state, so in our urban areas, we've still got limited access towards psychologists and psychiatrists. We have a recognised, you know, clinical shortage across the board.

I guess one of the things that we often discuss and certainly the National Mental Health Service Planning Framework tool is showing us where those gaps are in our workforce. But what it's not necessarily meeting for us is where we can actually try and address it more creatively. So are there roles and new layers that we can bring within our clinical services and qualifications and those streams to actually be able to look at upskilling some and then, creating some new roles so that we can fill the workforce needs that way.

The previous presentation around the counsellors was a good example of how do we actually look at expanding their capacity to be able to fill some of those gaps and certainly, you know,

we could be looking at nursing streams as well, where we could be upskilling certain areas so that they're going into those streams.

PROF WHITEFORD: So has Tasmania applied the National Mental Health Service Planning Framework that you mentioned? And it has showed you, which you've just said, is the gap; does it show you how to close the gap?

MS DIGOLIS: No, it doesn't.

PROF WHITEFORD: No.

MS DIGOLIS: No, it shows the size of the problem rather than the solution.

PROF WHITEFORD: I think the size of the problem can sometimes be, I guess, advantageous if applications are made for, you know, governments (indistinct) or other funding to help close the gap because it's not - perhaps, the fact that you're saying we need more - there's a benchmark which has now been accepted and used in many places to try and (indistinct) the size of the gap.

In the area of the service planning framework, has there been much application on the low intensity side of things where we could use, perhaps, counsellors or other people in that earlier part of that stepped care approach?

MS DIGOLIS: I believe that we've actually got the information now so we can start looking at that. We haven't got down to the point where we're actually saying, 'This is the solution to be able to do that.'

PROF WHITEFORD: Okay.

MS DIGOLIS: But certainly the information should be there across the full continuum of care for us to be able to understand how we may be able to go into those lower level services and ensure that there's a suitable workforce there as well.

PROF WHITEFORD: Because I think - and the last comment from me - some of that is about, I guess we might call that elicited efficiency, if we've got you know, psychologists working in the area where we can use them in an area where there's more complex need for example, we might be able to get a better distribution of those (indistinct) that is available and then, we know, perhaps, the most efficient way to get that coverage across that stepped care continuum.

MS DIGOLIS: And I think it's fair to say that we also haven't explored ehealth to the extent that we could as well. We can see that it is actually being employed in certain areas around the state, but I think it would be fair and reasonable to say that we haven't really looked at the effectiveness of it and how we might actually be able to get some greater reach by employing those types of methods as well.

PROF WHITEFORD: So, just again seeing as you've raised that, we have heard from Western Australia that they have expanded the MindSpot model of ehealth, which is run from

Macquarie University in Sydney through a program called PORTS and they've used that to cover parts of Western Australia, which would be more remote than most parts of Tasmania, and with some success and well taken up by the providers in those regional and remoter areas.

So I think you're right; I think we could do better in deploying that and a lot of the psychologists behind that program, as we understand it, are actually based in Sydney but they provide these services in Western Australia. So I think being more creative than we have been in the past, may be part of the - - -

MS DIGOLIS: Absolutely. And it's also the networking that we could look at within the health profession as well. So whether we could look at psychiatrists and psychologists being able to provide additional support to GPs than to people who are actually - health professionals who are actually based within our rural areas and provide an upskilling program in that was as well. That's another thing that hasn't actually been explored and could certainly provide some good opportunities.

PROF WHITEFORD: So I think - sorry, Julie; the last thing. We hear at these hearings a lot of - and we've covered a lot of them now - a lot of issues around these other problems, and the problems in Tasmania are challenging, but those problems duplicated across most of Australia unfortunately. What we are really keen to hear is what's worked. What's made a difference? If there's any examples of a solution that could be applicable across other parts of Australia, they're the ones that we can kind of capture and harness and get them into our report.

MS DIGOLIS: Great.

MS ABRAMSON: I have a couple of questions if I may, one is around psychosocial supports. When our report came out it gave an impression, which was not how we saw the world, that we thought that psychosocial supports were not as important as the clinical care. That was not the view of the Commission. But we need a little bit of help with a couple of things.

First of all, if your clinical need is quite low but your psychosocial support need is very high, we've been thinking around what might be the criteria for which you could then access the services. So we're happy to take that on notice. We've been asking a number of the participants if your trigger to getting your psychosocial support is not your clinical care if someone in your clinical care says, 'Actually, I need to refer you to a community-based mental health organisation.' It's how would people access those supports and on what basis might they access them. You can take it on notice.

MS DIGOLIS: Happy to partly to take it on notice because I think that's something that we could explore in our submission for January.

MS ABRAMSON: Yes.

MS DIGOLIS: But just in terms of a general response now, I think we've got - and you would've heard this - we've got to look at being able to simplify access for people and there's a lot to be said for peer support and for a peer workforce and we've been exploring how we can actually ensure that there are people with lived experience who are available in more points of the system, for individuals and families, to be able to discuss what their immediate, what they

believe their longer term needs might be and how someone with lived experience may actually be able to really enhance that pathway and be able to help them navigate those services. I think one of the challenging things around psychosocial supports around mental health challenges generally, is its always that point in time.

MS ABRAMSON: Yes.

MS DIGOLIS: So what that person needs on one day may be completely different the next day or the next week or the next month, and it's how we can be adept and flexible in being able to meet those regulating needs as they are at the moment in time, and whether that means that there's a contact service or a contact person - I'm reluctant to say care coordinator - but someone who's able to be able to provide that generalised support in helping them navigate what those services might be and the full breadth of those services then, perhaps, that's going to be able to improve people actually accessing the supports that are going to help them to function independently and at their best and healthiest.

MS ABRAMSON: Actually, it's interesting because I had not personally appreciated the distinction between peer support and peer workforce. So I'm really interested in having a bit more of a conversation about what you see as peer support and, as you would've seen in the report, we have a view about peer workforce and what not, but what does peer support look like?

MS DIGOLIS: To us, it looks like someone who can actually relate to any area of someone's aspect of life, and we've been exploring it ourselves because we're looking at some student models.

MS ABRAMSON: Yes.

MS DIGOLIS: And when we look at a student cohort then, their peers are their fellow students, and when they're talking about peer support, they're really just talking about somebody who may be a similar age group to them.

MS ABRAMSON: Yes.

MS DIGOLIS: When we're talking about someone who maybe having some mental health challenges and would actually like to be able to have some peer support, as they would see it, then, we're talking about someone who would have lived experience and who would be able to say to them, 'I'm not going to tell you how you need to do this or what your recovery needs to look like, but I can certainly loan my own experience to that,' and provide an example of what recovery can look like, and we're certainly learning the benefits and the benefits for the peer supporter but also, the person who's actually seeking that support in having someone being able to literally, you know, move shoulder-to-shoulder with them and say, 'I'm not going to tell you how to do it, but I've been there too and I can help.'

MS ABRAMSON: Thank you, the other issue is - we've made this request of a number of organisations in your position - is one of the things the Commission struggled with was seeing the workforce and the type of things that the community mental health sector does very clearly. When we looked at clinical support we could see gaps. But when we looked at the psychosocial

support we couldn't even see a system. In some cases, there was just a whole range of different services. So we're really interested in some more information about the type of services that are provided and sketching out some of the things that your members are actively doing with clients.

MS DIGOLIS: So, again, we can provide some more detail about particular programs in our submissions, but you can be looking at some high-intensive supports.

MS ABRAMSON: Yes.

MS DIGOLIS: So we would have packages of care that organisations are providing that would be providing usually time limited supports to individuals and families and they may have a clinical supervisor within that team, but largely, they might be looking at what we might refer to as more of an interdisciplinary team.

MS ABRAMSON: Yes.

MS DIGOLIS: So it's looking at the full range of needs for that person, whether it be housing, employment, education, training and actually focusing on their recovery. So you will find that a lot of organisations also use recovery tools.

MS ABRAMSON: Yes.

MS DIGOLIS: So the Star Recovery tool is a good example of that. It's very much around basing things on goal setting, on individual choice and on that individual being able to pace their recovery in a way that best suits them and, perhaps, that's why it can be challenging to understand and to be able to map the psychosocial supports because they do need to be so individualised and it can be difficult to be able to say, 'Here's a system,' when we're actually trying to deliver something and, in fact, I'd probably argue that the community managed mental health sector is, perhaps, the most effective deliverer of person centred care and that can consumer choice approach.

MS ABRAMSON: Yes.

MS DIGOLIS: And that means that it's very flexible and it can be a little bit more difficult to put your finger on exactly what's being delivered and you won't see consistency necessarily across services, but even within one service, because it needs to be able to be agile and to tailor for the needs of the individual.

MS ABRAMSON: But we've also heard in evidence elsewhere that it's been very difficult to get the workforce for - I mean you were talking before about planning - to get the workforce in some of these community-based programs. So I'm sure, if it's a problem in mainland Australia, I'm making an assumption it's also a problem in Tasmania.

MS DIGOLIS: It is a challenge here and certainly we have a shortage of allied health workers as well, but we can't ignore the funding issue.

MS ABRAMSON: Yes.

MS DIGOLIS: So it can be very difficult for community-managed services to be able to maintain and retain a workforce when they're constantly on two, one, three, five-year contracts.

PROF WHITEFORD: Yes.

MS ABRAMSON: Well, notice we had something to say about that.

MS DIGOLIS: Yes, exactly, so that becomes really challenging. That also brings - while we're touching on workforce again - that also brings that additional challenge about maintaining the professionalism of that workforce. So we have organisations that talk about actually having to put a hold on professional development for some of their staff because those staff are on short-term contracts. So they're not able to justify making an investment in further professional development for a workforce that may not be keeping because they may not have ongoing funding for that particular program or support.

MS ABRAMSON: Could I also ask you; how can we incorporate carers and family better in the type of supports that we provide? We've heard a range of things from the clinical side where it was quite acute where family carers said, 'I didn't know. I wasn't allowed to have information about my loved one,' which as you know, is a complex thing, but in the provision of these type of supports, how could we involve carers or family more, if we don't already?

MS DIGOLIS: And I know that you've got some care organisations who'll be able to provide more on that this afternoon.

MS ABRAMSON: Yes.

MS DIGOLIS: I think it's about, again, being able to encourage services and, perhaps, provide additional supports to services and organisations to really look at how they can upskill their staff, but also their programs in becoming more inclusive of families and friends as well.

It's interesting, on our drive up here we were actually talking about the challenge for mental health carers, in particular, and how that's different from other carers and, you know, acknowledging that it's often the fluctuating health of the individual which means that the needs for the carer and family member often change as well. But it's also, the risk that we actually overlook the needs of the carer, in particular, and I think while we are going for a person centred, individualised, tailored approach for recovery, I'm not sure how we actually incorporate the wellbeing of the family who are supporting, but I think there's certainly, rather than just looking at a narrow approach of how do we know that and ensure that the carer or family member is happy with the package of care that we have for their family member, how do we also ensure or take some responsibility for how that family member is actually managing things themselves and how their own physical and mental health and wellbeing is as well.

MS ABRAMSON: No, thank you, and we will ask some of the care organisations because one of the things that's been put to us is the need for carer support peer workers or peer support.

MS DIGOLIS: We've seen some fantastic models for that and we've certainly done some work in this state where we have some paid carer - - -

MS ABRAMSON: We'll be interested in that.

MS DIGOLIS: And I'm sure you'll have some organisations commenting on that this afternoon; but we certainly do have some recognised carer peer workers within our public mental health services. We've looked at some models internationally which are really interesting. We've talked about how families could be provided with additional support by carer services for example if they've had to have a family member, who's actually been removed from the home to be admitted, and how traumatic that can be for a family and how important it is for supports to be wrapped around that family, as well as the actual person who's unwell. So there are many things that we could explore that we would see would be a great benefit to families and carers.

MS ABRAMSON: We would welcome that in a submission. Just coincidentally, we have a team member here who's been working on the carers, so I should think she'll catch you later, so Harvey, did you - - -

PROF WHITEFORD: Fine, thank you.

MS ABRAMSON: Thank you so much. Could I have our next person, please, Ms Brett from the Psychotherapy and Counselling Federation of Australia? If you'd be kind enough to announce your name, where you're from, and I'm sure you've got an opening statement for us, thank you.

MS BRETT: Thank you. I'm the Chief Executive Office of PACFA, which is the Psychotherapy and Counselling Federation of Australia. So as the CEO of PACFA which is the leading peak body for counselling and psychotherapy in Australia, I have a unique perspective on the contribution that counsellors and psychotherapists can make to the mental health and wellbeing of the Australian community and in speaking to the Commission today, I'm going to be focusing on reform area 2 in the draft report; Closing critical gaps in health care services. However, I hope that much of what I have to say here today, is also broadly relevant to the Commission and to the ultimate goal of creating long-term reform that's sustainable and client centred.

It goes without saying that the mental health care system is in desperate need of reform to allow timely access to mental health support services by those needing this support. Clients should be able to access the right services from the most appropriate practitioners at the right time. This requires consideration of the whole mental health workforce, including counsellors and psychotherapists. This will ensure appropriate targeting of practitioners to client needs.

Now, your draft report found that there were gaps, not only in the funding and delivery of vital services, but also, in awareness of what constitutes mental ill health and the types of assistance available and the broad range of service providers who can provide that assistance. Counsellors and psychotherapists are a highly skilled, trusted, yet, underutilised part of the Australian mental health workforce. This inquiry presents an unprecedented opportunity to unlock the potential of this workforce and to break down barriers to access to counselling and psychotherapy for many Australians.

As I'm here to speak on behalf of PACFA and our members, it's crucial to understand the unique relation or therapeutic approach of counselling and psychotherapy as professions. The Commission has already heard, through submissions and evidence given in these hearings, about the importance of the therapeutic relationship between therapist and client.

Counsellors and psychotherapists are client-centred; that is what our training is. We are, by definition, relational practitioners. The therapeutic relationship between the practitioner and the client is central to our practice and it underpins the effectiveness of our treatments. Counsellors and psychotherapists are fully present with clients using empathy and deep listening to establish a positive working relationship with our clients. Counselling is effective when clients feel safe, understood, respected and accepted without judgment.

We work within clearly contracted and ethical relationships to support people to explore and resolve life difficulties. We work by respecting our clients, including their values, beliefs and individuality and their right to self-determination. So what this means is that professional counsellors use our therapeutic relationship as the centre of the way we work, but we're also using evidence-informed, intervention and strategies in the way that we work with our clients.

Now, you've asked at previous hearings what safeguards can be put in place to ensure the safe regulation of counsellors and psychotherapists, if we were to be included to provide MBS-funded services. I need to emphasise that these safeguards are already in place, and I will say more about this today.

Counsellors and psychotherapists that are registered with PACFA have completed an undergraduate or post-graduate training. They are trained in a range of modalities to work with children and young people, adults, couples, families and groups. They must meet clearly defined registration criteria, including clinical supervision requirements and ongoing professional development and they must work to a code of ethics.

So it's also important to understand that counselling and psychotherapy are interdisciplinary activities. So counselling and psychotherapy are provided by many different health professions, including counsellors and psychotherapists, as well as psychologists, social workers, occupational therapists and nurses, sometimes psychiatrists, and doctors.

Some of these health professions when they provide counselling and psychotherapy, they're doing that from a basis of a medical model. Whereas when the psychotherapy or counselling is provided by a counsellor or a psychotherapist with our specific type of training, it's a nonmedical biopsychosocial model.

MS ABRAMSON: I don't like to interrupt, but it's just I don't quite - it's not my training.

MS BRETT: Yes.

MS ABRAMSON: What does a psychotherapist actually do that's different from a counsellor? Because you've used the conversation a bit there, so I just wanted to understand.

MS BRETT: That's okay, I'll address that.

MS ABRAMSON: Yes.

MS BRETT: And, in fact, we have a one-pager which I can send to you, because I get asked this question all the time: 'What's the difference?' There's another peak body in Australia called the Australian Counselling Association. They essentially focus on counselling as a profession, whereas PACFA is psychotherapy and counselling, and the way we look at it is, they are different, but there's also a significant overlap.

So sometimes psychotherapists will talk about doing longer term work, more in-depth work, but I know counsellors that do long-term work and they go very deep. Sometimes counsellors might talk about being more solution-focused and short-term, but I know psychotherapists that sometimes do brief psychotherapy. So it's not black and white; there is an overlap. But probably from a professional identity perspective, psychotherapists would see themselves as having a different type of training formation.

They often talk about a tri-partied training model where the psychotherapy training involves three elements; the theoretical training, the supervisor practices - so we actually, within our training, do real work with real clients as part of our training. But the psychotherapists will have a third arm to their training, and that's personal experience of sitting in the client's chair and undergoing psychotherapy themselves. So it is a kind of lived experience in a way. We know exactly what it's like to do that work on ourselves.

MS ABRAMSON: Is that true of all psychotherapists or the ones that were in your association at Fairpoint?

MS BRETT: I would say it would be true of anyone who identifies professionally as a psychotherapists.

MS ABRAMSON: Yes.

MS BRETT: So some of them might not have been through a specific psychotherapy training in one modality. They might have done many different trainings, but the formation process of their life's work as a psychotherapist, has involved going very deeply into their own work. So, and counsellors do this as well. I trained as a counsellor, and certainly sat in the client's chair, as well as the therapist chair during my training, but this is perhaps emphasised more in psychotherapy training, but they've done a lot of their personal work, so they know what it's like to go through that journey of developing self-awareness, and grappling with our struggles and pain and difficulties and working through them with the support of their therapist. So, I'll happily send you the one pages, but it's not an easy question.

MS ABRAMSON: Thank you. I interrupted you, but - - -

MS BRETT: That's fine. That's absolutely fine. So let me see where I was. Yes, I was talking about some other profession work from a medical model. So what I mean by that is seeing mental illness as a disorder, a mental disorder, whereas the biopsychosocial model from which we work sees it as being multi-faceted. So we're much more focused on actively promoting mental health and wellbeing so it's that positive support within the model, as well

as focusing on treatment and prevention of mental illness. So, that does happen in the process of the talking therapy.

But very often – well, depending on what the presenting issue is from the client, we might have much more of an emphasis on prevention, early intervention, and support for mental health and wellbeing. So, I think that focus on client wellbeing is a unique identifier, or distinguishing feature of counselling and psychotherapy, as provided by counsellors and psychotherapists.

MS ABRAMSON: And you think that's different from psychologists?

MS BRETT: Well, it's hard for me to speak about psychologists, because I'm not – I'm not trained as a psychologist. But that was certainly my experience of counselling and psychotherapy training that I did, that it's very much a focus on wellbeing. It's very much more of a – I suppose you could say it's a holistic model, so it looks, like, at all aspects of our being, and our lives, and our participation in the community.

And in this regard, it's interesting; what you were asking just before about psychosocial support, because I have been a family carer for a few family members with mental health issues, and one of my family members who has bipolar disorder, has never accessed a formal service for psychosocial support, and assures me she has no intention of ever accessing that type of service. She says, 'Well, I wouldn't want to go there. Those people have all got bipolar disorder,' which makes me laugh.

So, but she has been encouraged and supported, by us as family members, to join her local pottery group. So, she's not going to get her psychosocial support by accessing a mental health services, she's actually participating in a local art group in her local community, and that's very supportive to her, and I know that if she didn't do that every Wednesday night, she would be at home, isolated, and probably, I don't know, spending a lot of time on Facebook and drinking a lot more alcohol.

So this is fantastic, that she has this positive outlet, and it doesn't always have to be a formal service. And I think this is where the encouragement and support of a counsellor is a way to support people to engage in what the community has to offer. That if you feel socially isolated and lacking in confidence, to go along to your local pottery group, that if you're having the support of a counsellor, and planning your activities on a weekly basis, what are you going to be doing to get out of the house, and doing something positive that engages you in your local community? I think that's where a counsellor can provide fantastic encouragement and support.

Can I say a little bit more about the training of counsellors and psychotherapists. You probably understand that there's a wide range of counselling from a diploma, or even no training at all, right through to undergraduate degrees, post graduate training and even a PhD, in counselling and psychotherapy.

MS ABRAMSON: We had evidence this morning.

MS BRETT: That's right.

MS ABRAMSON: Yes.

MS BRETT: So, counsellors and psychotherapists have what we would consider appropriate training, and who were endorsed by one of the peak bodies, they provide appropriate, cost-effective, treatment, and it's an option that we believe should be more easily available and accessible for patients with mild to moderate mental health issues. But this is where this, sort of, overlap between counselling and psychotherapy plays out, because it's not just that we see ourselves at the very bottom end of stepped care. Because if you've done psychotherapy training for six years, you're actually very skilled to work with people with quite complex issues, like personality disorders.

So it's not that – it's not as simple as saying, well, 'You stick counsellors down there, and you stick clinical psychologists up there in the stepped care model.' I think it depends on the practitioner, and it really depends on what their training is, and how experienced they are. So, I just wanted to make that point, because that picks up on some earlier discussions (indistinct).

PROF WHITEFORD: Sorry, can we just - - -

MS BRETT: Yes?

PROF WHITEFORD: Can we just grab it there. So, I guess the challenge that we've heard is that it does depend on the practitioner, and that not all counsellors or members of PACFA are the same. And even though there's standards, and there's supervision, and you've tried to create that consistency, that there is a continuum of skills and experience across the membership, which would be the same with, you know, a lot of other organisations as well. So, how can we match, as you said at the outset, the skills of the practitioner and the needs of the client in a stepped care approach, or whatever approach. In a big population health level, that's the challenge we've got - - -

MS BRETT: Look, I don't know if you know about this, but Adelaide PHN is doing some really interesting work. They are developing, and I think they're already implementing, a centralised referral system. So, the GPs, and I think a large number of GPs are participating in this centralised referral system. So rather than just doing their own selection of a psychologist, they'll come into the Adelaide PHN central referral system, and an assessment is done to actually match client needs with practitioner needs.

So, someone came in, who needed more intensive work, and if we get the reforms to better access that we're hoping for, and people will be able to access more than ten sessions, because some people sorely need more, it may be that they then get matched with a psychotherapist who is skilled to work with their kind of issues.

MS ABRAMSON: Except that, the psychotherapists – I might have got this wrong, but the psychotherapist doesn't have the access to better access. So the better access section's only for the psychologist.

MS BRETT: That is how it is at the moment. But what's really interesting about what they're doing with Adelaide PHN is, yes they've got the pool, right now, of the Medicare providers for better access, but they're actually including counsellors and psychotherapists in their referral

pool, because we heard somebody else speak this morning about how there are patients who have the capacity to pay for private counselling. But the default referral pathway is, 'Well, here's a referral with your mental health plan to go and see a psychologist', and actually, that particular patient might be better served by going privately. They have the capacity to pay.

We are starting to see some rebates for private health insurance being available, for counsellors and psychotherapists. We need a lot more, and we're working on that, but we have BUPA now, and that's the most positive and accessible private health rebates. Some of the other health funds, it's a bit of a limited offering of rebates, whereas BUPA has really come to the party - - -

PROF WHITEFORD: Sorry. So on that: there is, we're well aware of this initial assessment and referral that the PHNs have been asked to do, this IAR approach that they've all been asked to take on to try and match the individual needs to the appropriate intensity of service. And what you've just said is that for some of the commissioning dollars, that the PHNs have, they're looking at the providers in the geographic area, and trying to match the individual clients/patients coming into the system with that, and remunerating that service by commission dollars, rather than Medicare benefit schedule?

MS BRETT: Yes.

MS ABRAMSON: Yes, okay.

MS BRETT: We're interested in that model, and you're jumping ahead in my presentation.

PROF WHITEFORD: Sorry.

MS BRETT: What I wanted to say is, we're working right now, without partner of the Australian Counselling Association, we're working on advocating for counsellors and psychotherapists with appropriate qualification, to be added to the better access initiative. And your question earlier today was interesting, you know, is that the best way, or could counsellors perhaps sit outside the system? I don't see it as an either/or.

I absolutely think counsellors and psychotherapists need to be added to that system because we have significant workforce shortages, and also there are issues of client choice. So, let me say something about client choice, because this is where the research evidence really helps us, because people are more – the research finds that people are more likely to seek help if they can consult the practitioner that they actually feel comfortable with, and want to work with.

And sometimes, what happens is you might access some counselling through an employee assistance program. Maybe you develop a great relationship with that counsellor, but you've only got six sessions through your EAP. You want to carry on with counselling, so you go to GP – you go to the GP to get the referral, but your counsellor actually hasn't got a Medicare number. So you actually have to stop with that counsellor and start again with someone who's got a Medicare number, possibly a psychologist. So we've got an interruption to the continuity of care. So, if the client had the opportunity to continue with the counsellor they're working with, the evidence – the research evidence says that will actually support better outcomes.

So, the other issue is, some people have an experience with a particular practitioner, and it doesn't always go well, and they might shop around. Or they might terminate treatment after only one or two sessions, because they don't feel a connection. So I think the research evidence tells us that they may get a better outcome if they can actually choose the practitioner that they feel comfortable with.

MS ABRAMSON: But how do we – and I know we're interrupting you, but how do you get the positions of the consumer to make an informed choice? Out there in consumer land, there are all of these services, taking a provider that a consumer is prepared and able to pay, how would they know which service to access? What would your organisation say about helping them access services?

MS BRETT: Look, I think there's more work to be done here. We're doing a piece of work right now to enable people to search on average as to specialisation. So, some people have done their bibliotherapy, and they know what they're looking for, because they've been reading up about it. Others haven't really got any idea what might help them. But they might be able to search by specialisation; they might want a psychotherapist, rather than a counsellor; they might want a relationship counsellor. So we have a college of relationship counsellors. So if their core issue is around relationship difficulties, they might want to seek out someone who has that specialisation.

Now, I think is one of the real failings of better access. It's very generic, and it's very narrow, the type of interventions that people can access. And I actually think it's also really important – like, it's almost a bit like government doesn't trust a highly skilled practitioner to choose the most appropriate intervention.

MS ABRAMSON: The government worries about the funding for these things.

MS BRETT: I'm sure. But the government says, 'You're only allowed to do focused psychological strategies', which is essentially CBT and a few other miscellaneous types of treatments. So instead of treating the – trusting the practitioner to choose the most appropriate intervention, that's imposed. Now, I trained in (indistinct) counselling, so I don't just use one thing. I can actually integrate a range of different treatments, in response to what the needs of the clients are. So, you're right, the client might not know what they need. But you actually have a professional therapist, who actually can do an assessment to determine what is actually going to be most appropriate and effective.

MS ABRAMSON: You have to have that triage process, though, and what you said about the Adelaide PHN, really is part of the model there, that somebody is making an assessment.

MS BRETT: Yes, yes. I'll just tell you a little bit about the research evidence. There's research into the common factors underlying the effectiveness of counselling and psychotherapy, and I can send you more - - -

MS ABRAMSON: We would actually be pleased to see the research, and the evidence.

MS BRETT: Yes, yes. So I'll send you this, it's got research evidence, but I've got some additional research references that I can send you. The common factors research talks about

how all types of therapies, broadly speaking, achieve broadly similar outcomes. So actually, it could be a psychologist doing CBT, or it could be a psychotherapist doing gestalt set therapy. The common factors research finds that all of these types of therapy achieve broadly similar outcomes, and it's the strength of the client therapist relationship that's the key determinant of the outcomes.

MS ABRAMSON: How does – this is just the lawyer in me, so I'm apologising in advance, but how does that make your case that they – that the government should fund psychotherapists and counsellors, if psychologists are already getting those outcomes, what's your argument as why your organisation, if it's the same outcomes? I'm not – this is just for the purposes of us having a conversation, it's not (indistinct) - - -

MS BRETT: No, I understand. Well, there's certainly research evidence that says CBT is effective, but it's not effective for everyone.

MS ABRAMSON: But you're saying it's who delivers the CBT that's - - -

MS BRETT: That's right. So you could have a really good psychologist delivering it, or you could have a really good counsellor delivering it. But you might have a psychologist or a counsellor that doesn't develop a good therapeutic relationship, and it might not be effective. So it's actually not about the practitioner, it's about the relationship the capacity of that practitioner to develop that relationship. And this is where we come back to counselling and psychotherapy training, because our training is relational. So we actually are, I believe, really good at developing therapeutic relationships with our clients.

MS ABRAMSON: But I wouldn't thought the idea of therapeutic relationship would apply for any treating professional that you see? It doesn't matter whether it's a counsellor or your GP, or whatever, it seems to me it matters for all of those type of things.

MS BRETT: It does. But I think what I want to say about our training is that – let me come to that part of our – my presentation.

MS ABRAMSON: We are a little time pressed.

MS BRETT: Okay, all right.

MS ABRAMSON: And I know we've interrupted you, by the way.

MS BRETT: That's okay. I can't see the part in my presentation - - -

MS ABRAMSON: We certainly welcome a written submission.

MS BRETT: Look, I'll put this in. This would be in addition to the written submission about (indistinct) January. I can send you this, because I've actually - - -

MS ABRAMSON: Would you like that taken as a submission, as well?

MS BRETT: Not today, it's got my scribble all over it.

MS ABRAMSON: No, but you can email us, and we'll take it as a formal submission.

MS BRETT: Yes. Well look, all I wanted to say about the training is, this is by definition what counselling and psychotherapy training is. It's a relational training. We don't do a degree in psychology to learn about cognition and behaviour. We do a degree to learn how to sit with a room – sit in the room, with the client, and work with them, relationally. So, if the common factor's research says, this is the key factor, determining positive outcomes, what I'm saying is, we are trained in that.

MS ABRAMSON: All right, I understand.

MS BRETT: So I think that's a unique contribution we can make.

MS ABRAMSON: Yes.

PROF WHITEFORD: Time for one more quick question from me?

MS BRETT: Okay.

PROF WHITEFORD: How many members does PACFA have?

MS BRETT: We've got about two and a half thousand members in these categories, that we're recommending, not lower categories. We're in partnership with the ACA, and they, I think, have slightly higher numbers. So together we have the Australian Register of Counsellors and Psychotherapists, and I think there would be more than 5,000 registered practitioners, 25 per cent of whom are in rural and regional areas.

PROF WHITEFORD: And that's the group you believe would be eligible to – excuse me – provide the services you're talking about that could be rebate-able through better access?

MS BRETT: That's right. And if I could say one more thing, which I just want to highlight right now, and you'll read about it when I send this to you on the email: we recognise that the MBS is not the whole system. It's a big part of the current mental health support system. It's a bit inadequate for purpose, and it certainly needs developing and improving, and we believe that the addition of counsellors and psychotherapists would go a long way towards improving it. But that's not the whole of the system, and we actually welcome the emphasis in the Productivity Commission's report on other types of funding models.

So, we'll put something in writing, in January, about some of the issues about the quality and consistency of services, when they're being commissioned locally. But it is true, and we support the fact that there are many other ways to do the services, and there should be other funding models. So yes, by all means, let's improve better access, let's strengthen the workforce, let's expand the workforce, let's make more than just psychosocial strategies available through that, because there are many other effective treatments. But let's also look at other funding streams.

MS ABRAMSON: We're very interested in that, and we would encourage you very strongly, in your submission to talk to us about other funding mechanisms.

MS BRETT: I will, yes. And there are many places that counsellors already work, private practice, non-government organisations, where there are some excellent services.

MS ABRAMSON: The other thing in your submission is we're very interested in outcome data, so cost of service and their outcomes, so any information you have on that. And you've been very patient, because we have interrogated you, so I thank you very much.

MS BRETT: No, that's okay. I expected to not get through the presentation, but that's why I've got it ready to go in writing.

MS ABRAMSON: Thank you so much.

MS BRETT: Thank you.

PROF WHITEFORD: Thank you.

MS ABRAMSON: We will now take a break for lunch, and we will resume at 1.30. Thank you.

LUNCHEON ADJOURNMENT

[12.40 PM]

RESUMED

[1.29 pm]

MS ABRAMSON: Thank you. I'll reconvene the hearing. Just a few reminders from this morning for the new participants that are here. We like to conduct all our hearings in a reasonably informal manner but there are clear structures in our legislation to how these hearings are legally backed and full transcript is being taken. For this reason, comments from the floor cannot be taken. The transcript from today will be made available to participants. Additionally, I am happy to take other participants at the end of the day as we do have a little bit of time if there are people who have not put their appearance in and wish to be heard.

Participants are not required to take an oath, but they should be truthful in their remarks and you're welcome to comment on the issues raised in other submissions. You're free to enter and exit the room as you want. If you experience any distress, our staff are here to help you and our staff are over in the corner over there.

In the unlikely event of an emergency requiring evacuation, please follow the exit signs to the corner car park at Thistle and Glen Dhu Streets unless given an alternative assembly location by fire wardens. And given that we're visitors here, I should think we'll be following you out the building. So thank you. With that, could I please ask that Caring Fairly, Adele Beasley, if you'd like to take the stand and if you could say who you are, on whose behalf you're appearing

and if you have an opening statement, we'd be very happy to have it. Thank you. Are we good to go?

MS BEASLEY: Thank you. My name is Adele Beasley. I'm here representing Caring Fairly. And I am also the manager of policy and campaigns at Mind Australia. But today representing Caring Fairly. So thank you so much for the opportunity to speak to you about the important role that carers play in society. And congratulations to the Commissioners on a monumental draft report.

We think that there is much to be excited about in this report and we thank you for your commitment to addressing the needs of carers and families. I also wanted to take the opportunity to thank you for the collaborative nature in which you've conducted the inquiry. You've been out and about and speaking to a lot of different people and taking on board a lot of different comments so thank you for that.

So today as I said, I'm representing Caring Fairly which is a movement that wants to lead a new public conversation about the value of those who care. Caring Fairly is coordinated by Mind and is supported by a growing coalition of allies and grassroots supporters from across Australia. It's particularly focussed on policies that bridge the gap between unpaid care and workforce participation. So we have invested in leading and (indistinct) leading edge research and produced evidence based policies that provoke fair and more inclusive outcomes for all unpaid carers in Australia. At home, in the workplace and in society.

And while Caring Fairly represents all unpaid carers, we'll limit the focus today to mental health unpaid carers and we'll also concentrate specifically on mental health carers' participation in the workforce, allowing the other carer representative bodies to focus on care inclusive practices more generally – more specifically, I should say.

So we believe that this inquiry represents an opportunity to think about the care economy, so ensuring that valuable work does not bring about negative effects on employment earnings and financial security. We note and welcome the Commission's focus on person-centred care or consumer-centred care and think that this involves both – this can involve both the consumer and the carer because we know that that relationship is not linear and that carers can become consumers and consumers can become carers.

And so therefore, it's not a neatly defined role. And when you think about the person being affected by mental ill-health and we need to understand how that affects the families and the carers and their loved ones. So – which also extends into the workplace. And so when we're talking about mental health – mentally healthy workplaces, we also need to think about how carers play a part in having a mentally healthy workplace.

So we think the measures that are outlined by the Commission in the draft report will go a long way to addressing the needs of carers and families, but there's just some additional points that we wanted to focus on for today's discussion.

So we note and welcome the focus on the carer payment and carer allowance. And we welcome the recommendation into improving flexibility in regard to the 25 hour rule but want to sort of speak further about how – whether there is actual scope to abolish this rule entirely. And

because the draft report says that it – that the 25 hour rule, the check that carers are actually providing a significant amount of care, but as you state it's an imperfect control because the (indistinct) is about time spent on some activities but not all such as leisure time. And it does not take into account the episodic nature of some mental ill – mental health care needs.

And we know that carers are effectively on call to the person for whom they are caring for even when they're not actively providing care and we know that emotional support makes up the bulk of the care and responsibility as well. So we also note that the Commission says in the report that you're sensitive to the need to prevent people from claiming benefits to which they are not entitled. And suggest that the taper rates apply in terms of removing 50 cents to the dollar, goes a lot of way to ensuring that people are not claiming the benefits to which they're not entitled.

And the overall intention of, you know, precluding people from working, studying or volunteering for more than 25 hours per week seems to be at odds with Government policies which encourage people to attain further qualifications and progress financially.

In relation to the carers and work program, we welcome your recommendation to evaluate the carers and work program to inform guidelines that job active providers can use to tailor their services to the needs of current and formal mental health carers. Thank you.

I'd like to speak specifically about the flagship policy for the Caring Fairly campaign, which is to implement a national framework for care-inclusive workplaces. So we believe a coordinated Australian Government policy framework is needed to guide workplace reforms, create incentives and address the specific needs of carers in accessing equal employment opportunities.

PROF WHITEFORD: Sorry, just people sometimes in the back can't hear if the voice drops. So if you just – you know, it's hard in this room.

MS ABRAMSON: And the microphone's only for the transcript so it doesn't amplify.

MS BEASLEY: So unpaid carers need tailored employment support services and while workplaces need to adapt and change, in parallel leadership and coordination, must come from the Government. Caring Fairly advocates for a national framework for care inclusive workplaces. We believe this should involve relevant departments such as the Department of Social Services, investing in co-designing framework that can be implemented.

I'd also like to speak about women and care. So care and responsibilities can emerge for anyone but data shows that the effects of unpaid care on employment are experienced more acutely by women than men. We therefore suggest the Workforce Gender Equality Agency is involved in discussions about care inclusive workplaces. And we also note that the Commission has hasn't addressed superannuation in your report.

MS ABRAMSON: Not in this report.

MS BEASLEY: Not in this report. So whilst we understand that it may be beyond the scope of this report to fix superannuation more broadly, we do think it's worth consideration for

mental health carers specifically given that we know that women are more likely to be carers than men and women retire with a lot less superannuation than men. So the Commission may want to investigate providing a superannuation guarantee or an associated benefit to people who are on carer payments.

And in relation to young carers, my last point, we note the Commission's reference to young carers in the report and thank you for understanding that this cohort have unique needs. We understand that you're addressing this concern by recommending wellbeing leaders are placed in schools and as part of their responsibilities, they should support schools to better identify and support young carers.

We'd like to emphasize that there needs to be formal links with community mental health providers to be able to refer into them and to support young carers after they finish school. And Mind has actually undertaken some research in relation to young carers. We have a research project we're undertaking called Educational Engagement for Young People Who Care for Parents with Mental Ill-Health which aims to understand the young care experience in relation to education and the point of view of the young carer, their parent and their teacher.

MS ABRAMSON: When will that research project – what's its timeline?

MS BEASLEY: It's very much in its infancy unfortunately for this report.

MS ABRAMSON: Yes.

MS BEASLEY: So I will – I'm hoping to be able to work with our researchers and see what we can be able to provide for you in relation to this report.

And that's all for my opening statement, so thank you.

MS ABRAMSON: Thank you very much. I'm interested in learning a bit more about the mental health carers' participation in the workforce document that you talked about and what you're recommending? I have seen some of the notes here, but I really welcome having it for the transcript.

MS BEASLEY: So Caring Fairly advocates for a national framework.

MS ABRAMSON: Yes.

MS BEASLEY: So as part of this framework, there should be existing initiatives to address the mental health stigma in the workplace. They should be extended to recognise and include the impact on employees who are caring. Employers should directly provide information and commit to offering or providing linkages to support services for carers within the workforce. They should – employers should be encouraged to adopt a policy for examining job re-design possibilities such as flexible workplace arrangements, homeworking, leave arrangements and those sorts of things. And employers should be encouraged to undertake job redesign to accommodate carers with intensive caring commitments that extend, you know, beyond three months or require more than 20 hours of care provision per week.

Carers Australia has a working care initiative guide and so it could draw upon this guide to implement the framework. And in the UK, to look at an international example, there's the UK Carers Action Plan and this is an example of multi and cross-departmental agencies working together in order to improve carer's participation.

MS ABRAMSON: Thank you. We're particularly interested in small business and I'm just wondering, in the context of small business, how some of these things could be accommodated. So certainly for large businesses and if you've got multiple sites, you know, there – you've got much more flexibility, but one of the things that we've looked at in the report in particular is if you're in a small workplace, what can be done and we've been thinking who could support smaller employers and that might either be Government or industry (indistinct) so we're interested in your views on that.

MS BEASLEY: I might have to take that one on notice and take that back to our coalition and have a chat to them because I know from the discussions I've been having, we have talked about you know, doing a – the benefits of having a pilot or a test and that may – the tests would probably be better suited to a larger organisation who has the resources to be able to do this. But I'll take it back to my colleagues and have a think about it some more.

MS ABRAMSON: That would be great. Thank you. Also, what is it about mental health carers that's different from other carers in terms of the workplace? We had some ideas about that, but it would be good to hear it directly from you.

MS BEASLEY: I think it's about the episodic nature of mental health, because you can't guarantee when you're going to be needed and so therefore, there may be periods where you are, you know, when you need to be with the person who you're caring for at all times. And then there may be periods where that person is well and they are able to look after themselves. So it's the unpredictability of that relationship and of that caring responsibility.

MS ABRAMSON: Well, it's interesting because we certainly looked at that when we looked at the big programs that were being delivered, it didn't really deal, you know, social security, didn't really deal well with episodic nature and that's why with some of those work tests and things, we had a really good look. The biggest sort of stricture on us is that we were only looking through the lens of mental health, but of course, carer payments affect a broad range and we couldn't be sure if we made a change in one area, what the impact would be on the carer group overall. So were a bit more narrowly focussed. Harvey?

PROF WHITEFORD: No, I think the main thing is to, I guess, understand the difference for mental health carers, because a lot of the programs we saw when we looked at this were designed for carers of people with physical disability and didn't cope well. It was like as we've said in the draft report, it seemed like mental health was bolted onto a program that was originally designed with that in mind. The (indistinct) often didn't reflect some of the nuances, I suppose. So, how to deal with that would be useful. I guess the other thing was that many carers said that it wasn't about replacing the care they provided by a paid professional, because (1) they didn't want that replaced and the consumer didn't want that replaced either, so it's about the flexibility that the carer would need to continue to provide their caring role. Is that the thrust of what you're - - -

MS BEASLEY: Yes, that's exactly the policy of Caring Fairly. It's beyond (indistinct) Government to replace that care. I know that you've estimated the economic value of that and it's huge. But it's, yes, it's exactly as they're saying. It's about the flexibility to maintain that caring role, but also be able to balance the need between having a paid job and being able to take on that caring role, so we think about it in terms of a care economy.

PROF WHITEFORD: Yes.

MS BEASLEY: Basically. And how we can have those flexible working arrangements in order to enable people to do both and to get value from both.

MS ABRAMSON: I'm also interested – we had a bit of a discussion this morning, you may want to leave it for your colleagues that are following but carer peer support, it's not something I'll be honest that I had actually thought of. We thought about peer support for the consumer, so just interested in what that looks like from your perspective.

MS BEASLEY: I may leave that for my colleagues if that's okay.

MS ABRAMSON: Yes, of course.

MS BEASLEY: We have talked about that.

MS ABRAMSON: Who I hope are in the room at the moment.

MS BEASLEY: We have talked about that and Caring Fairly obviously speaks with other caring organisations. We've talked a lot about that. It is important to note the difference between consumer peer support and carer peer support because they are unique cohorts.

MS ABRAMSON: Yes.

MS BEASLEY: Acknowledging that there – it's not a neatly defined relationship as I said before. But they are unique cohorts of people. So there are some differences.

MS ABRAMSON: No, thank you for – the other thing you might be able to comment on. In our report, there was evidence that the economic and social outcomes for young carers of mentally ill people were substantially worse than – for young carers of other types of disabilities. In fact, I think we saw that – like, the team's in the room - but we saw their attachment to education was worse, which meant that their employment prospects were diminished. So we're very interested in that with a proviso of saying, well, what would the replacement care be so that young carers could concentrate more on education and things like that so we're interested in any news on that and happy for you to take that on notice. We just want to make clear that we know that's an issue but we're looking for some solutions.

MS BEASLEY: Okay.

MS ABRAMSON: Thank you. Harvey?

PROF WHITEFORD: That's fine.

MS ABRAMSON: No? Thank you very much.

MS BEASLEY: Thank you.

MS ABRAMSON: Thank you. If I could ask Maxine Griffiths from Mental Health Families and Friends Tasmania. If you'd be kind enough to take your seat, to announce your name, where you're from and I'm assuming you have an opening statement you'd like to make?

MS GRIFFITHS: Thank you very much. My name's Maxine Griffiths and I'm representing Mental Health Families and Friends Tasmania. Mental Health Families and Friends Tas is a peak body established to support and advocate for and with families, friends and carers of people living with mental ill-health. We have been and remain involved in Tasmania's recent reform announcements to integrate State Government managed mental health services to better meet need in Tasmania.

We articulate our jurisdiction's needs at a federal level through membership to our national body, Mental Health Carers Australia. We welcome this opportunity to have a say about the draft report authored by the Productivity Commission. Mental Health Families and Friends wants mental health reform to embed person-centred principles with individuals, their families and carers involved in all aspects of system design, implementation and review.

We want to see services that respond to the individual needs and preferences of people. Not people fitting into an inflexible and uncoordinated system, that on the face of it appears to be meeting the needs of service providers funded by Government rather than families, friends and carers and consumers in need. We want to see governments genuinely address and respond to the social determinates of mental health. Access to secure housing, appropriate levels of education and access to meaningful employment. We want to see a system that addresses the whole person, including their most important relationships with their families, their friends and broader community, and lifestyle needs and preferences.

We want to see services that are responsive to the needs of families as they travel the often irregular sign-posted journey to wellness and some form of reasonable functioning.

We see this inquiry as an essential component in mental health reform. This represents a key opportunity to see real change to the way mental health services are planned, funded and delivered, from early intervention and prevention to acute care, to allowing all Australians to eventually take responsibility for their own mental wellness.

We note that for many people, their families and carers are with them at every step of their journey through the mental health system. For those who have not had a close family or friend relationship, we hope that services and general community members will look beyond the actual delivery of service and see the whole person.

Families and supporters deserve better. Their voices need to be heard and they need to be afforded the dignity and recognition that has been lacking for so long.

In response to aspects of the draft report, it's noted that the report focuses on clinical aspects of

mental health services and not so much psychosocial aspects.

MS ABRAMSON: I'm happy to speak to you further about that.

MS GRIFFITHS: Thank you. Family and carer inclusion is not embedded in the overall document, indicating perhaps a lack of understanding of the relational model of care and support and the reality of the commitment and care that's provided by families, friends and unpaid carers.

The development of a national consumer and mental health family and carer co-production framework could be applied across all system and service settings, mandating the use of the Practical Guide for Working with Carers of People with a Mental Illness across all service provision.

In Tasmania, our chief psychiatrist has committed to support the rollout of this guide across all public community mental health services. How that will be funded, I'm not sure.

In the section where we talk about workforce, we don't see the mention of the large family carer workforce, larger than the paid workforce. What is to be done to sustain this undervalued and currently stretched workforce. Carer-inclusive practice must be mandated just as the recovery of model of care is for individuals. The Carer Experience Survey which has been rolled out across the country is not enough, as it's not binding or connected to funding outcomes.

We believe that the stepped care model needs to include families, friends and carers. Innovation is not mentioned, and there's no incentive for services to innovate.

A carer peer workforce needs to be included in commissioning bids from service providers and should be mandated by funders. We support a national approach to a carer peer workforce with appropriate training, professional support for workers and a career path across all jurisdictions.

What's missing in Australia is a family and carer non-legal advocacy program or service, and we need this to be supported and sustained.

We note in the report that it doesn't talk about comorbidity, so where a person may have a mental illness but may also have either an intellectual disability or a drug and alcohol addiction. Services in Australia tend to be siloed, which adversely impacts families, friends and carers.

The PC recommendations need a much greater emphasis and investment in a relational based approach to recovery, with a stronger vision that better integrates clinical and psychosocial as one system supporting the lifetime journey of consumers and their families who are impacted by mental ill health.

We would like to see more detail about how a specific national mental health carer peer workforce could be funded and deployed. We've heard that many families and carers have benefited from the wisdom and experience of those who have been before them on the recovery journey. We believe that a dedicated mental health carer peer workforce could provide social and economic benefits that are yet untested and strongly support the implementation and evaluation of a national mental health carer peer workforce.

We also believe that the report needs to talk about reducing barriers to accessing income support for mental health carers, and access to super whilst providing ongoing support has been brought to our attention. Thank you.

MS ABRAMSON: Thank you very much. I have quite a few questions, if that's okay. One of the things that we've said to a number of other participants and my colleague, Stephen King, did a major speech on this to Mental Health Australia. Our report looked like we were preferencing clinical services over psychosocial, which we weren't, and we know that they're interconnected, but we also know that there is a cohort of people for whom the psychosocial supports are the really important part and they may be clinically stable or not want to access clinical services, so we understood that we hadn't fully articulated that, and in our final report we've understood that point.

Which comes to my point. We need a bit of help from the sector. One of the reasons that the report looked the way it did was because whilst we could see gaps in clinical services - we could see exactly where they were - with psychosocial supports, a lot of the support was hidden for us, because it wasn't measured or we didn't see the workforce. So we've said to a number of stakeholders it's really helpful if you can outline to us - you're talking about carers. These are the type of supports that make a difference. These are the type of supports that are being accessed, and where you know what the funding support for those, so that would be a great help to us.

I'd like to know a little bit more about the national consumer and mental health family and carer co-production that you spoke about.

MS GRIFFITHS: We believe that one of the most important things that we hear from families is that they want to be involved in the development of a policy, of service design, because they have, from their lived experience, some valuable experience to offer. So we can go about this by saying that Tasmania could do it our way and Victoria could do it their way, but we think we have an opportunity here to have a national approach around co-production and co-design so that there are some basic principles developed around what it is, what it isn't, so that families themselves, once they understand what those principles are, they can actually start to ask to be involved and possibly demand to be involved.

In our experience in Tasmania, there seems to be a variety of interpretations of what co-design and co-production is, so I think to help all of us across the country to have a standard framework which would help all jurisdictions would be very helpful.

Now, what that actually looks like, I can't say right now, but to me it's about having some fundamental principles to guide service design and to guide organisations on how to include families and friends and also consumers in the design of services, so it's like a how to.

MS ABRAMSON: We have struggled a bit in the report between competing issues, which is the privacy around a consumer, especially, you know, that awkward age sort of with adolescents. When they're adults, it's even more difficult, but a number of carers have said to us, 'It's really hard because we couldn't find out what the problem was with our loved one, or what the care was,' so there was that part of the family, and then there were other consumers

who said, 'Well, I didn't actually want my family to know but I would have liked this support person to know.'

We've also been given evidence that when the question or the conversation is approached appropriately by the medical professionals, that most of the time people do give consent and it's the way in which they have the conversation with the consumer about the release of the information to the carer, so I'm just interested in your views on that.

MS GRIFFITHS: Yes, certainly from our experience when we talk to clinicians and when we talk to mental health staff, they sometimes say to us, 'Well, we don't know how to have the conversation. We don't know how to start it.' Or they may have had experience where they've had a 'no' several times, so they're reluctant to ask again, but on the whole the majority of clinicians and medical staff feel that they can ask the question and if there's a, 'no' first, they will ask again and it's usually okay, but it's also okay to have a 'no'.

I think there's sometimes some confusion about what it is that families want to know and it often is not the content of the conversation between the consumer and the clinician. They really want to know is everything going to be okay. Is everything all right? Or, 'Because I'm the carer at home, is there something that I need to know to look out for?'. So I think we need to be clear about what it is families are asking and for clinicians and mental health staff to understand how to have the conversation, and that confidentiality often doesn't come into it because it's not the content of conversation that often families want. It's that --

MS ABRAMSON: No, that's very helpful. Harvey?

PROF WHITEFORD: So there was a few things you mentioned that didn't seem to be covered in the report. Comorbidity was one. So there's a whole chapter on comorbidity, so I'm just wondering what in that chapter we missed or wasn't in there?

MS GRIFFITHS: So around the siloing. I think if I can speak from a family's perspective.

PROF WHITEFORD: Sure.

MS GRIFFITHS: That is, providing support to a person who has a range of issues; one might be mental health, one might be drug and alcohol, in Tassie at least, we have very siloed services, and so that families may receive support in very different ways from the mental health sector from the drug and alcohol sector or nothing from the drug and alcohol sector and really good support from mental health, and so it's that that families say to us they get very confused and concerned that there's a mix of supports or they don't know what their rights are in each of the areas.

PROF WHITEFORD: So we've identified that, because many people did tell us that. The recommendations we've made about how that could be improved; was there anything in addition to the recommendations we made which could help?

MS GRIFFITHS: As far as families go, I think it is more about family inclusive practice, particularly in the drug and alcohol area that in Tasmania families say is either non-existent or it's very slim, so it's about ensuring that there is a family-inclusive practice set of principles

and application in both sectors, so families can understand that they're going to receive the same level of support for both.

PROF WHITEFORD: I guess we've not speaking specifically, I suppose, about the drug and alcohol sector. We understand the issue about comorbidity, not just drug and alcohol but, you know, physical comorbidity in other areas. Is it because the information isn't made available when asked or, you know, is it that carers in Tasmania are excluded because of issues around privacy or whatever the barriers are that we haven't been able to overcome?

MS GRIFFITHS: Are you asking around the drug and alcohol area or – -

PROF WHITEFORD: No, around mental health.

MS GRIFFITHS: Around mental health.

PROF WHITEFORD: Where there is any comorbidity, I suppose.

MS GRIFFITHS: Okay. I think it's around information, and I think it's around not knowing what the signposts are that take you on the journey. The signposts that take you on the journey around mental ill health are over there and the signposts that take you on the journey elsewhere are over here. There's nothing in the centre that sits with the family and says, 'Okay, these are the circumstances.'

PROF WHITEFORD: Bring it together.

MS GRIFFITHS: We need - yes, yes. So there's not a whole of family approach to the issue. We tend to have bits and pieces happen to families in Tasmania.

MS ABRAMSON: Just following on from that, do you have a preference for what layer of government should be providing the support, because in our model we've talked about regional commissioning on the basis that we want people to plan locally and commission locally for the services of that population, but you've very clearly articulated the mismatch of trying to bring all these together.

MS GRIFFITHS: Yes.

MS ABRAMSON: Do you have a view about who should provide the services, from a government perspective?

MS GRIFFITHS: From a government perspective. I'll go back to what happened in the disability sector. I had experience around that in Tasmania when we closed down our institution, Willow Court, where the state government said, 'We're no longer providing services. We're going to hand service provision over to the community sector,' and that happened, and I was very involved in it. In the mental health space, I'm very confused about why the state government provides somethings and then the Federal government have this and that. I get very confused in trying to map out what's what when I'm talking with families. It would be so much better to have more clarity about who provides what, who funds what. I don't have a preference, but more clarity, and perhaps we may need another look at the whole system

to say, 'Well, these sorts of supports will only be funded by blah and other more acute supports are only provided by XY.' Certainly on behalf of families, more clarity is required.

If I find it hard to make sense of the space, I certainly see that families do and will continue to do so.

MS ABRAMSON: The other thing that I was very interested in is you talked about advocacy, non-legal advocacy, and we do have some recommendations around the Mental Health Tribunal, but clearly what you're thinking about is broader, so I'm interested in understanding that.

MS GRIFFITHS: I'm thinking about advocacy support for families. More than often, we come across families who are really struggling to understand systems, to understand XYZ, and to have someone walk alongside families when they're in that, you know, confusion, sometimes the journey for families can be years and years, and I certainly note that we have funded advocacy for consumers. We do not have that for families, and we're asked all the time by families, 'Will you come and help me write this letter?' or 'Will you come to this appointment with me?' but we can't because we don't have the resources.

So it's that kind of thing would be really really helpful for families, to sustain their capacity to continue the care that they provide, and in my jurisdiction, that doesn't exist.

MS ABRAMSON: Are you thinking of putting in a submission?

MS GRIFFITHS: Yes, we will be.

MS ABRAMSON: Because I would encourage you to particularly make that point to us. The other issue that you spoke about was accessing superannuation. The Commission has done a great deal of work in superannuation, and apologies to your colleague, Ms Beasley, who spoke before. I meant to ask you further about super. What is the issue?

MS GRIFFITHS: Okay.

MS ABRAMSON: Is it the super laws don't allow for access to the super?

MS GRIFFITHS: Okay. We have - I could think of half a dozen families right now, all women, middle age, who have had careers, who have had to leave their job to carry out some caring responsibilities over a number of years, so their super has ceased. Over a number of years they've been providing support. Some find it impossible to get back into the same career because if they're a GP, for example, they've missed so much that it's really hard to get back. It's that that concerns us, and it's particularly happening to women, and I am concerned that if we are relying on the informal support that in particular women provide, this issue is going to become more so. What can we do in order to protect those people who are providing that support for their long-term income into the future? And if the person they're supporting after three or four years is going really well and they've been able to recover to a point where they can live a meaningful life, then the carer is left going, 'Well, hmm, what about me now?' and some people have had to, you know, go into the kind of work that they don't really want to. They'd rather be back into their profession but haven't been able to.

MS ABRAMSON: It would be really useful in your submission if you could outline those circumstances because I think any thinking would not be around - I mean, I can't speak on behalf of my colleagues, but the government funding the super. It would be more like, what are the transitional programs that would help carers get back into the workplace.

MS GRIFFITHS: Yes.

MS ABRAMSON: And that certainly would be a space we would be interested in.

MS GRIFFITHS: Thank you. Thank you.

MS ABRAMSON: Thank you very much.

MS GRIFFITHS: Thank you very much.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Thank you.

MS ABRAMSON: We're running a bit ahead of schedule, but if the Royal Flying Doctor Service Tasmania are here, we'd like to hear from you. If you'd be kind enough to announce who you are and who you're representing, and I expect that you might have a short opening statement. We have some water for you on the table. Sorry, we've called you up early.

MR KIRWAN: That's all right. We're enjoying the discussion.

MS ABRAMSON: We've given you an earlier landing spot.

MR KIRWAN: John Kirwan, CEO of the Tasmanian section. Nicole Grose, our manager of primary care. Can I just make some - - -

MS ABRAMSON: Absolutely.

MR KIRWAN: Yes. Just first of all, I'd just like to endorse the Mental Health Council of Tasmania's submission earlier today. We're a member of the Mental Health Council and we think they're doing some innovative work.

I won't speak to aeromedical, because I understand the federation may make a comment themselves and we published them in that work last year or earlier this year. Earlier this year now - that goes to the aeromedical side. I'll focus on our primary care in Tasmania specifically, and Nicole can go to the detail because she manages the program, so I said, 'I'll do the easy stuff and she can take the hard questions.'

So just a general comment. I enjoyed the report. I wouldn't say I've read it all in detail, so the comments are not meant to be critical; more a case of emphasis, and some of your earlier responses and questions have already picked up some of those, so I'll try not to be too duplicative.

One area that I would make a comment on, and I think it's implicit in the report is one needs to actually define what mental health is, and I know having worked in an acute hospital there was often, dare I say it, demarcation disputes between various parts of the medical profession, let alone within parts of psychiatry and others, social work and others, as to what was mental comorbidities, we've already touched on, and others, and I think there is an issue.

I say that particularly because my interest now is remote and rural. That's our areas of practice, and it is often not a clear medical model. It is not a case of where you can have a psychiatrist or a psycho-geriatrician or others, and so we actually do need to work within what is in scope, and again I listened to your earlier comments. We would always favour a more holistic approach, particularly in remote and rural areas that picks up physical health, emotional, social wellbeing, but particularly early and again, you commented on that in respect to the public comments. We are cautious about a model that starts with a mental health diagnosis rather than it starts more upstream in those sorts of areas.

So one of our programs we can explain doesn't require a diagnosis, so we have a mental health staff and youth mental health staff in the field. They just need the referral, and that referral pathway can be from various different pathways.

Not surprisingly from general practice, a lot of it, but we also find that a lot of people are not keen on being - because of the stigma, having a mental health diagnosis and what does that mean.

Holistic care is very important for us and that goes back to how we were founded over 90 years ago and particularly working in what the Commonwealth would call areas of market failure, trying to be as holistic, trying to fix what we are seeing as much as possible then and there, and that's the model the RFDS still tries to have across Australia to this day rather than a medical specialist model.

I would make a comment, and you just touched on it about your regional purchasing. I worked in government and health system for over 40 years now. I caution about top down reform, because I don't think it's worked, so if you are going to reform I think there has to be, as we just heard from either the families or the carers, peer workers, there needs to be pressure from the bottom up, and particularly Canberra led top down reform, and I say that because the trickledown effect to remote and rural areas of a one size fits all, I really do caution in some of these areas, particularly when you can't necessarily in early days be all that clear what you're dealing with or what the underlying issues are.

Timely access is critical in our view, and we are seeing that time after time, particularly although Tasmania is not as disadvantaged when it comes to GP coverage as what some of the mainland states are, particularly more remote areas, but we are seeing increasingly more and more locums as GP positions aren't being able to be filled, and not necessarily GPs with an interest in mental health. So the GPs are only locums, don't even know what the existing NGO and other services are, pathways become clouded because they're only there for a week, sometimes shorter, and what does that mean?

So again, that pathway, and I noticed in one part of your report, if I remember it properly, I did

notice a focus on the GP has been critical. We would say it's probably more critical earlier on in respect to those referral pathways, and as I said, we accept referrals from pharmacists and from others.

I should probably then touch also a little bit on the workforce. I've come to a view, and probably not a popular one, that if we expect to see our traditional six-pack of mental health professionals in some of these remote and rural areas, I think you're dreaming, to be blunt. We probably need to look now at a new model of care, and in my speaking notes I sent through, there's a new associate degree at the university here that actually does potentially present a more generalist model at a level below the degree level. Now, I know that's heretical to a number of the professions, but I do point out the success of Aboriginal health workers led by the medical profession when they actually realised that we weren't going to have doctors and nurses in all of these communities, so at least a presence to help in early detection, prevention and referral.

So again, if we're looking about reform, I think if we think we're going to stay with the traditional workforce in remote and rural areas, we will be unpleasantly surprised. And again, we published some work this year that showed what the workforce is looking likely to be in the next 10 years, and in the mental health and allied health spaces, and that cuts across disability, aged care and acute care as well. It's pretty skinny in Tasmania for a range of reasons, e.g. most of the allied health professions aren't trained here, so we've got some real challenges if we want it fitting a model that may work well for a big city into an area where there just isn't - they aren't there.

MS ABRAMSON: We're really interested in seeing that data, if you'd like to send a submission.

MR KIRWAN: Yes. I understand what you're saying on pooling and funding, coming back to that, but as someone who in his earlier career was in fact a purchaser commissioner in Western Australia, my experience is unless you quarantine some of that, what will happen is it will triage itself to the highest area of need, and in Tasmania the acute mental health area is struggling significantly, so if it's all in one bucket, as happens in a hospital today or a health service today, there's not much that goes out on a preventative health program because the ambulance ramping today, the elective surgery waiting list today, will get the priority politically and otherwise.

So pooling does make at one level, particularly joint commissioning, mapping, making sure services are going where they should be, does make sense, but the reality, when put into that system, you need to have those stop gaps and guarantees, in part because the remote and rural people don't get a voice very easily, and as we know they've got one sixth access to services in mental health, so we need to address that.

The comments on social determines health I think was encouraging, and I think we need to expand that forward again. Your commission can't fix that, but we do have issues here. Intergenerational unemployment in youth, under-employment, housing and other areas like this, and if we are really going to address some of these things, intergenerational issues, they are not easy but they do need to be named up and we do need to start working our way through them.

I'm not too sure when you mentioned the role of teachers. It may or may not be. We have youth mental health workers, which Nicole can explain, that work in the schools, so whether they are a better option. I just have some concern about putting too much onus on teachers in respect to maybe early detection, but some of the lead roles I'm not too sure that's quite going to be the best response.

The generalist model I'll leave Nicole. I just would finish off in respect to just coming back to the workforce, and again, looking to different models going forward, and again, we have had success within a generalist model of rural health worker, physical health workers and mental health workers working together as a team and working as closely as we can with the GPs. That is, although a number of them aren't qualified, we haven't employed them as social workers or psychologists but as generalists, and that's fairly important, I think.

I think probably social participation in these areas is probably the last thing I would touch on. That is to say I think we don't probably see, although you speak to experienced practitioners and of course they'll say they do practice social prescribing, but if you've got a very busy GP practice that's effectively operating on six-minute blocks to be able to push through the numbers, their ability to sit down and investigate and work out other support systems that the client or the patient can actually have is very very difficult, even if it's a referral to a Men's Shed or others, they're having to pump it through. But the system under a fee for service payment system does not encourage that type of a social prescribing model that we see probably better defined in the UK and other places.

MS GROSE: Thanks. As John said, our model is based on a holistic model where we support people socially, emotionally and physically, so anyone that gets referred to us or self-refers into the mental health space, we also support them with their physical health with an exercise physiologist, OT or similar, and we're getting really good health outcomes from that.

We find with a lot of our staff in the rural areas referral pathways are very difficult, so we need to be more generalist to be able to support those people and not necessarily need to refer on to more acute care. We do work closely with GPs and that's working very well.

Comorbidity is - 90 per cent of our clients come to us with comorbidities. Mental health and physical health go hand in glove, and as Reverend John Flynn said 90 years ago, the mind and body are integrated yet inseparable, and we see that all the time and that's how we work with the program.

PROF WHITEFORD: There's quite a bit there. So just for my clarification, obviously there's a lot of work that's not aeromedical. Can you just run us through that so we just understand the space that you work in that's not aeromedical?

MR KIRWAN: So the RFDS is a primary care provider, including our aeromedical primary clinics and other areas, but we're probably best known for our aeromedical retrieval work and transfers. That is nowhere near the majority of our work. In Tasmania we have a contract for aeromedical service for the ambulance service, so that's retrievals and transfers, so it doesn't deal with clinics. So each of our six sections is somewhat different, so it does depend on what we're funded for by either the Commonwealth or indirectly the Commonwealth or in state

contracts. So we are a federation under one brand, but we are a different model.

However, the common theme is primary care, of which we would see - we include mental health and dental health. The dental health is a whole challenge in itself. And should I say in this space as well in respect to emotional and social wellbeing and for people who have got no teeth or rotted teeth, social disadvantage, exclusion, not applying for jobs, not leaving the house and all of those things. So that's a whole separate topic as well.

We here have a primary care service and that includes our dental team, so we have on the ground, not flying, about 35 staff in two different models. Where they're place based wherever possible the staff live and work in the community. Where it's a mobile service which literally means that they work in one area and move to another, they'll come in Monday morning and come back Thursday night. Sorry, they'll leave Monday morning and come back Thursday night. Be away four days, three nights in the community they're working in in that week, so we try and do week blocks in those areas.

PROF WHITEFORD: And the employees you have within that service? What types of professionals would you have?

MS GROSE: Yes, we have clinical psychologists in some areas, we have social workers, mental health social workers. It just depends. We really try to recruit locally as well to help the whole community and the economy and everything else, so it depends on what - it changes depending on what community.

We also have exercise physiologists as well, physiotherapists.

PROF WHITEFORD: Okay.

MS ABRAMSON: Can we get some data on the types of services that you provide to people with mental illness, and what types of services? That would be really useful for us.

MS GROSE: The types of service is we provide support for adults and that's in eight different rural areas. We also provide support for youth aged between eight and 16, and that's in six rural and remote areas. So the youth program is only very new. That I think would be three or four months on the ground, and the adult services have been on the ground for two and a half years, and we're fully subscribed in all of those areas and we have wait lists in quite a few as well.

MS ABRAMSON: How does the youth program relate to headspace, which is quite a presence in mainland Australia?

MS GROSE: Yes. So when we got the funding for the program, we worked very closely with headspace and Cornerstone to ensure that we didn't duplicate services and we filled the gaps as well, so we worked closely with headspace here to ensure that the areas that we went to, that they couldn't provide the service. Once again, you know, there's limited funding so you can only go so far, so we worked - and we worked at an early cohort as well. Our program you don't need a referral and you don't need a diagnosis. So quite often we will be the first point of call, and then we can refer on to other services where necessary.

MS ABRAMSON: Could I also ask you about suicide statistics, or attempted suicide, to be honest; whether in fact it's much higher than what we're actually seeing from the data that's reported from the hospitals. Like, there's an under-reporting in a busy emergency room. It's not treated as an attempted suicide, and the reason that we're - well, we're interested because it's such a huge issue, but also we're strongly of the view that there needs to be support after people leave hospital on an attempted suicide, but of course if a hospital is not recording that actually was an attempted suicide, then they're not even going to be in the pathway for additional services to be provided. So do you have any experience in that area?

MS GROSE: I know from working in small communities, everyone sort of knows everyone or knows what's happening, and I think it's under-reported definitely.

MS ABRAMSON: Yes.

MS GROSE: I don't know exact data, and a lot of times the families don't want it to be identified as being a suicide or attempted suicide as well, so it's stigma once again associated with it. But we definitely hear a lot more about it in rural and remote areas because I think it's the small communities that we're working in.

MR KIRWAN: If I can just respond, in our cardiopulmonary rehabilitation program, stage 3 rehabilitation, so it's not rocket science, but working with people who are post-event, we've had significant success in the north of the island in reducing the waiting list at the LGH for those cardiopulmonary areas and improving the health outcomes, so follow up after an incident, appropriate follow up after the incident, I think I would see no reason why that model wouldn't and shouldn't equally apply in mental health, but it is again of making that accessible, making that comfortable and what we found when we had an evaluation done by UTAS, one of the things that people reported most was the saving of not having to spend money to drive into a regional centre. And for some people that was \$300 a month if they had to come in for three sessions, in the end they just didn't.

MS GROSE: Or in the cardiopulmonary space as well, as John said, we do phase 3. A lot of people that have a cardiac (indistinct) can have their license taken off them for up to six months, and if they live in rural and remote areas they can't get in for the rehab and then it creates that anxiety and it's stress on the family members as well. Yes, so community-based follow up would work well, I think.

PROF WHITEFORD: Can I just go back to your funding issues, so your primary care, you mentioned there are multiple sources for your funding. Does that include - like, are some of your providers able to bill the MBS? Is that part of it or is it contracted and salaried staff that you have?

MS GROSE: No.

MR KIRWAN: Our two programs, one is through the chronic disease funding from Primary Health Tas. We were successful in tendering across four chronic diseases of which mental health was one of them, and so that again reinforces the holistic approach that we work in that area, and more recently through Commonwealth direct funding to the Royal Flying Doctor

Service nationally was a mental health program, and then in consultation with Primary Health Tas and the department, and others, that's where the mobile youth service was seen. Again, we tend to work in areas modified Monash 5 and above, and in areas where we try very hard to avoid any duplication with existing services. Having said that, often people will say that they provide a service in an area, not just mental health, but we'll find that that's once every three months.

PROF WHITEFORD: Yes, sorry, I'm wondering whether the data there for, on the services you provide, is captured in anything statewide or national, aggregation of mental health?

MR KIRWAN: That's an issue for the higher FDS, as you're probably aware. We're one of the only two block funded services, us and Aboriginal Medical Services. So our data isn't normally captured in MBS, PBS type capture, because it's fee for service, that's a nice data set to then pull out, but you don't want to (indistinct) or whatever it is, but we do capture all of our data, in the minimum data sets, and that's the word that I referred to earlier that's come out of the federal office, by extracting it out of our medical records, we use MediRecords, assuming everyone has entered their medical records, appropriately, which is an ongoing challenge, although now we're accredited, it's an issue that we now audit against, to maintain our accreditation.

So the data is there, but not – to answer your question, not automatically captured in those other data sets. That's why some of our national reports, like our medical work, we're the only ones that hold the data set.

PROF WHITEFORD: Yes. I'm just looking at the team over there, we want to make sure we've got that coverage. Not just, obviously, for Tasmania, but what you've told us about the national - - -

MR KIRWAN: It will be – I mean, because our staff are salaried – having just said that, I think most of them are – but also on the mainland, so we don't work in the Medicare funded system, and so the data is captured separately from that, which often means where we're active, it's under reported, if you're only using those traditional data sets.

PROF WHITEFORD: And I know you're not covering the aero-medical retrievals that you do, but we – while we have you here, we're going to take advantage of that. So, do you have anything to tell us about with respect to the transfer of people with mental illness, where they're being transferred via RFDS, and if you want to take that on notice, that's fine. But I guess, we're trying to get a handle on that, because we have heard that that can be quite a challenge at times.

MR KIRWAN: It can, and it is, as someone who comes from Western Australia, originally, I'm conscious of those challenges. There is the report, that we released aero-medical retrievals for mental health crises, and the level of support. If it's not in that work, I'm sure that Dr Fergus Gardiner, who's our epidemiologist in Canberra, can probably help with that area. So, if we've got it in a data set, it will be available, and again our new National Executive Officer, Frank Quinlan, so again, those areas are - - -

MS ABRAMSON: We're very familiar with Frank.

MR KIRWAN: I'm sure you are. Again, I think that – I was surprised when this national report came out at some of the figures.

PROF WHITEFORD: Yes.

MR KIRWAN: As to how high it was, because I know there's normally a reluctance in transferring mental health patients - it goes to issues of sedation and escorts and things like that. But if you've got no choice, you've got no choice.

PROF WHITEFORD: Thank you. Sorry for interrupting.

MS ABRAMSON: Thank you very much. Thank you.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Could I ask, I'm assuming our next participant's here. Ms No, from Victims of Psychiatrists. If you'd be kind enough to take the stand, or take a seat, announce your name, and who you represent. And I'd also invite you, if you wish to do so, to make an opening statement.

MS NO: Ms Initially No. I organise for Victims of Psychiatrists. We're a collective of people, it's also a generic term, for people who have been through forced psychiatry. We organise protests, and also petitions, and support people who are suffering the harms of forced psychiatry. We also intersect with a number of marginalised, oppressed groups of people, including people who have allergies, sensitivities, to petroleum based substances in therapeutic goods.

Now, to read this draft report, Victims of Psychiatrists have to replace the hate speech; that is, the mental health jargon used by our government officials to attempt to justify the persecution and torture of victims of psychiatrists. Hate speech causes a barrier in being able to read such a document. Mental health hate speech is a threatening reminder of previous and current violations upon our people, and gets in the way of doing the job. For those who have, or are being subjected to forced psychiatry, rolling out more mental health associated propaganda, in workplaces and schools, will only make matters worse.

Mental health propaganda also ignores obvious workplace hazards that cause difficulties which often get put in to the unhelpful category of mental health issues. Most especially, the accumulation of toxins in the air space, primarily caused by personal products and poor ventilation. To expand mental health training, into work places and not look at any kind of air quality control is really dangerous, and placing mental health issues on people who are suffering from prolonged exposure to poor air quality is a violent thing to do.

To then expose such a person to even more toxic air spaces in hospitals and exerting coercion and force upon a person to take chemicals that they are already sensitive to; psychiatric drugs that carry a warning of drowsiness, inability to operate heavy machinery, that's not going to contribute to a person's productivity at the workplace - - -

PROF WHITEFORD: Can I interrupt you for a second, sorry?

MS NO: - - - where better air quality and better regulation fragrance products would have done so.

PROF WHITEFORD: We've got the submission you've made, and we certainly got that. Would it be better if we could ask you some questions about it, to associate things we're not certain about? Because we've got that and we can make any of it available in the public submission space.

MS NO: Could I have five minutes just to outline this?

PROF WHITEFORD: Sure, absolutely. Yes.

MS NO: Emergency medicine, intention to treat and audit are used as reasons to forcefully experiment on victims of psychiatrists in invasive, cruel, life destroying ways. A range of exploitation is then turned into profit and loss statements. So this is point number two: in the same way – this is done in the same way there profit and loss statements as laboratory animals are financially costed. Only the victims of this exploitation are said to be the cause, and any costs of the organisation that they incur, including wages, are put upon the victims of psychiatrists, like we're totally to blame for all these costs.

Victim blaming is not an unusual tactic in an exploitation racket, and it's historically common, yet it's obvious people held in servitude to psychiatrists, who are held by force, who are not paid, who are being violently exploited by the mental health system are the economic boom. Unpaid laboratory specimens, gosh. They're not permitted to leave, and that's a disgusting thing for a democracy to allow, and I'm sure it's not what Australians want to fork out 130 billion per annum to harm us, and pay the psychiatrists for. So I'm asking for strong scrutiny of mental health companies that wish to expand through government grants. I think that's what's needed.

Particularly companies that force their products, procedures, and programs on people, and utilise government legislation to deny people the right to refuse; that use coercion to get people to do their programs, or voluntary work at their services, in exchange for perhaps a little bit of mercy from the maltreating mental health team.

MS ABRAMSON: Ms No - - -

MS NO: Victims of Psychiatrists – can I just finish? Victims of Psychiatrists have had their livelihoods stolen by the mental health industry, and the government that legislates and invests in this. At the point of vulnerability, when we were lured in by the idea of talking things through with a psychiatrist or psychologist, and when we were maltreated, the mental health personnel would just not let us walk free. Took away our independency, destroyed our careers, and while torturing us with their products and procedures, demanded we agree with everything that the psychiatrists dictated, that the products that retarded our intellect, physical abilities and creativity, that also disfigured out attractiveness, destroyed our fertility, was something benevolent that we had to agree we need, or we'd never be free from arbitrary detention, or in the toxic psychiatric ward.

And we found if we kept trying to speak out against this, psychiatrists would increase their torturous products, procedures, programs, and tell us that putting us to sleep 22 hours a day with forced neurotoxins, made us better. So, an expansion of mental health associated industries is not economically viable, or ethically suitable to a democracy. That's the way we said, as first person people who have been subjected to this. I'd like to see these industries survive when people have the right to refuse. That would be a good test of true need, competition, productivity, as well that insulting charitable status, claiming the necessity for the violence they inflict upon us.

MS ABRAMSON: Thank you for your presentation. I wanted to ask, on an area where I think we have common ground, which is about legal advocacy, for people prior to compulsory treatment. The Commission has made a recommendation where we've said that people need to have access to advocacy, whether it's a legal – a lawyer, or it's other advocacy services. So, what are your views in that area? Because I understand that you're keen to see more support there too.

MS NO: Yes. In Victoria, and other states as well, the availability for legal aid is very low, and legal aid also need a lot of time to be able to set precedents. So it's basically, they're tackling government legislation that's very, very old. The last Royal Commission in Victoria, for instance, was in 1886 on mental health - - -

MS ABRAMSON: Although there is one currently running - - -

MS NO: There is one happening now, but we have conflicts of interests. Two psychiatrists on the board. No victims of psychiatrists, and, you know, I was not heard at that, so I thank you – I thank you for hearing us here now, and I was not able to make the Melbourne one, because we had a fellow person who stands at parliament with us to change the legislation, taking in by psychiatrists. So we have to do enormous amount of work.

MS ABRAMSON: What's the legislative change that you're talking about?

MS NO: The right to refuse. It's like the right to refuse a shop. It is just a shop. It's got products, procedures, programs. We should have the right to refuse that. It's logical, and to have an industry that, you know, is able to grab people to say, this person, even though they don't want us, government, you're going to pay money for us to exploit this person for human research. Now, that's another thing, is that they're not even really following the legislation, in Melbourne, effectively. They are actually running mental health tribunals like a compliance test. Like politics, and an opinion on being mentally ill. And that's not legal under 4.2.

MS ABRAMSON: Well, the thing that, as I've said, that we've concentrated on, is providing support at the time that the person appears before a tribunal.

MS NO: It's good for legal aid to do that, but if they're just running the mouse wheel, right? But for most of the time, it's only ITOs that are lucky enough.

MS ABRAMSON: ITOs?

MS NO: Yes, sorry. Internal treatment orders.

PROF WHITEFORD: Interim.

MS NO: Sorry, yes. So, they're people that – and even then, they won't necessarily get a lawyer. So this is like, really under representation. But here you've got a whole lot of people, you know, wanting to refuse this, and a government's saying, 'No, we're going to let these people,' and no oversight on what these psychiatrists are doing when they're breaking the law.

MS ABRAMSON: So, your interest is - - -

MS NO: The tribunals are rubber stamping things.

MS ABRAMSON: I understand what you've said to us. So your interest is in the appearance before the tribunal, accountability of the tribunal, and the tribunal people, and as participants as well.

MS NO: Yes. I'm also interested in – I mean, people have needs in society, you know? People go through grief, and they – they want to be able to see a counsellor, but they don't want to be dragged in forever into a – because that's the thing. Somebody goes to get this need, and then suddenly, they – a lawyer can't do anything.

MS ABRAMSON: What would have made a difference to you, when you're thinking about your circumstances? So, what would the system – like, I've understood what you've said about the ability to refuse treatment, but are there any other services that could or should have been available?

MS NO: It's about, if a person's being harmed by somebody, so there's many, many situations. So for instance, I mentioned the one with the toxic products. That's really under acknowledged, by both the medical and government as well. So there's a whole group of people that are – Anne Steinem does wonderful research on this. She was a civil engineer, but she also suffers from this condition. We've also got author Kate Greenfall, who talks on it as well. So they're people well-known.

But a whole lot of people, over 35 per cent. And we're going to workplaces and, you know, feeling horrible and all that. There's also domestic violence stuff. Organised crime; people can't talk about this stuff, you know? That's really scary to people. So I did work in peer support for a bit, right? So many different things happen to people and they can't even talk about those things that they need justice for, or those things that they need justice for they can't get that, but the worst thing of all is they can't get justice for a psychiatrist violating them.

And that's just – I mean, that the government is violating them, and their population is saying, 'This is help and this is care.' So insulting, so life destroying. People can't work on these drugs, and in your Productivity Commission, you're saying, 'Well, let's make them even,' you know, 'less cost to our government.' These people are being shut down. You know, people with brilliant, you know, abilities, being electroshocked to the haemorrhage. You know, these drugs that are being forcibly injected into you. Causing epilepsy and - - -

MS ABRAMSON: I think – we’ve heard what you said, and - - -

MS NO: And then they want to do secondary research. It’s disgusting.

MS ABRAMSON: Can I just say, look, thank you for bring it to our attention, thank you for being so passionate. And I think my colleague has a question.

PROF WHITEFORD: So just quickly, when you say that the law’s being broken – so when there’s legal representation at a tribunal, is it that the lawyers aren’t doing their jobs, or is that the legislation within which the lawyers are working? If we made legal advocates available, the legislation’s got it wrong, from your perspective?

MS NO: The legislation should allow the right to refuse, and then – we don’t want, like - - -

PROF WHITEFORD: Sorry, can I just – no, sorry, can I just – give me a chance. So - - -

MS NO: - - - 13,000 forced orders in Victoria - - -

PROF WHITEFORD: So, the legislation should have the right to refuse. So, are you saying that therefore there should never be a situation when a person could be involuntarily treated, ever?

MS NO: No. If Australia has signed and ratified the U.N. CRPD, the Rights of Persons with Disabilities. That clearly states that we should have the right to refuse medical treatment. And how can you say a blanket medical treatment is right for everybody?

PROF WHITEFORD: No, I just – my question was, in your opinion, should there never be a case where someone - - -

MS NO: Absolutely, absolutely.

PROF WHITEFORD: Okay.

MS NO: If it’s a police matter, it’s a police matter. But if it’s a psychiatrist judging my mentality, as a woman, and it’s a male psychiatrist, and - - -

PROF WHITEFORD: No, I heard your answer. I heard your answer, thank you very much.

MS NO: I mean, excuse me, this happens way too often. And women are persecuted by these monsters. They’re also sexually abused by these monsters. In fact, on that attacked me is now in gaol. So, I’m talking a psychiatrist. So this is – these are not people to be trusted. They’re not people to be expanded, you know, for us to give more money to. They’re people that really need to be investigated, not only state-wide, but under 8.2 and 8.3 of the Responsible Research Code, because audits and intention to treat, and you know, codes to forcefully exploit people for human research – it’s really dirty.

MS ABRAMSON: Thank you, Ms No, and thank you for speaking so passionately about it.

PROF WHITEFORD: Thank you.

MS NO: Thank you for letting us have this spot today, and people of Tasmania. Launceston.

MS ABRAMSON: Thank you. Mr Floyd? I believe you'd like to speak. If you'd be kind enough to state who you are and who you represent, and if you have a short opening statement, we're happy to hear that.

MR FLOYD: Thank you very much. Sorry, the last – well before seven years ago, I had no idea about the massive criminal activity of psychiatrists in our community. I spent seven years as a VCAT, QCAT, Supreme Court, County Court advocate, pro bono, spending my life now every day working to help people slaughtered and killed and damaged by psychiatrists.

MS ABRAMSON: I'm sure, Mr Floyd, that our staff have already mentioned to you not to mention any names of any individuals.

MR FLOYD: Of course.

MS ABRAMSON: Thank you.

MR FLOYD: Now my name is Glen Floyd, pro bono advocate for all those court jurisdictions. I got the United Nations to order Australia to stop electrocuting a public case, Garth Daniels in Queensland. It's publicly known out there, and there's no suppression order on Garth.

So I help vulnerable persons massively harmed by widespread, fraudulent psychiatry in four recent and current cases, and I'm the convenor of the Australian Abolish Psychiatry Party. Twenty-five years senior management person in Telstra, top 3 per cent. Ran a charity for the last seven years and ran a recruitment business. I have worked my entire life in a community contributing to those areas for the last seven years. I had no idea this massive death and morbidity was taking place, caused by psychiatrists.

Widespread, fraudulent psychiatry kills 80,000 Australians per year. There is a current ABS stats, every year, 80,000 Australians killed by psychiatrists and psychiatrists' drugs. That's the morbidity levels.

MS ABRAMSON: Excuse me, Mr Floyd, do you want those taken as formal submissions?

MR FLOYD: Yes, I'll hand on in to you at the end of my speech, if you like. That is the ABS statistics, okay? So they're current statistics, but that's nine years old. It was 76,800 then. It's now over 80,000, killed by psychiatrists and psychiatrists' drugs. They're the two categories of where these massive deaths are occurring. You stack up those 80,000 corpses head to toe, they would run from Melbourne to Bendigo, an hour – two hour drive away. You'd just look out the window running at 100 kph and watch dead corpses for two hours, killed every year.

Widespread, fraudulent psychiatry kills 80,000, as I said. There's the ABS statistics. Psychiatrists are humanity's deadliest pandemic scale predator. These people are being killed by psychiatrists and their drugs. Heroin drug pushers only kill 750 Australians every year. Psychiatrists' drugs kill 10,700 per cent more than heroin drugs.

MS ABRAMSON: What would you like to see done, though? What would be your path to reform?

MR FLOYD: My path to reform will come at the - when I finish making these points. It's widely held by lauded professionals inside and out psychiatry such as Peter Breggin, Niall McLaren psychiatrists are that psychiatry is evil in the house of cards. These are psychiatrists saying this. Adjunct professor Dartmouth College Patricia Deegan, clinical psychiatrist, states that, "Psychiatrists dehumanise and depersonalise to the point of spirit breaking, destroying social justice and the right to humane treatment and rehabilitation," as initially now has just stated. A person telling you she's on the receiving end of this.

Psychiatrists destroy lives, families and productivity. The mass death morbidity regime has no foundation or basis whatsoever in psychiatry. It's fundamental fraud for financial reward, and clearly earmarked with such by the following factual statements. Psychiatry is purely fraudulently concocted, pseudo medical conditions. They do not exist. People suffer massive emotional traumas in their life, but they do not have a brain disease, and there's no cause shown whatsoever. There's no biological markers or pathogens shown for bogus conditions such as schizophrenia, et cetera.

These conditions cannot be tested to be existing, and toxic drugs are put into people for them, like you're giving a vaccine for a known disease of measles, when the forced lethal neurotoxins, example, carfentanil, 10,000 times stronger than morphine, yields no biomedical impact on the person, then psychiatrists make fraudulent condition statements such as, "The person's got treatment resistant schizophrenia," and push more drugs, that are purely concocted with no evidence base whatsoever, you know, drug resistant schizophrenia.

No other medical branch of evidence does this. If you've got a pathogen, you're given a medication that can kill the pathogen. There is no known biological marker for any of these psychiatric fraudulent diseases. They are purely concocted treatments with no validity, no reliability and no disease cure whatsoever. All bogus diagnoses classifies the person as a danger to themselves and others, and no substantive evidence shown whatsoever is given to show this fact that they're a danger to themselves and others, just capricious statements. Totally removes the person from society.

For example, in Victoria, there are 115 per cent more forced orders in Victoria than New South Wales. Sister state, same demography, and the commissioner in Victoria at the moment, Bernadette McSherry said, "This is lamentable, it cannot be." Victoria's got double the rate of psychiatric forced admissions. Same state. It's statistically impossible. It's fraud. It's psychiatrists pushing these diseases for money.

Out of the 3,100 deaths in 2017, 86 per cent were caused by lethal new toxic psychotropic drugs. Only 14 per cent were people who suicided without these drugs. Most deaths of psychiatrists' patients, that's the 80,000, are not due to physical health conditions. Coroners never show the lethal neurotoxins causing these drug reactions, suicide deaths, which is shown on the manufacturer's black box warnings.

There's a massive conflict of interest inherent in the racketeering psychiatry paradigm, whereby a vast financial gain in two direct areas falls directly to psychiatrists and other players to deliberately, fraudulently diagnose non-existent mental health disorders for massive financial rewards. They are a vast one, salary funding cabal of corrupt, racketeering psychiatrists, social workers, nurses, hospitals. They're taking money to force brutal and cruelly inhumane and degrading torture, which is what the UN calls this: a clear violation of our UN – United Nations CRPD. And you recommend more. The death rates are massive.

MS ABRAMSON: Mr Floyd, we're happy to take written submissions. I'm a bit mindful of the time and allowing other people to have their say.

MR FLOYD: I won't be long. I understand, I won't be long. So I spoke to Tasmania's psychiatrist general Aaron Groves in 2015 in Melbourne, and he got up after I made this same submission. He said there is evil in psychiatry. This is the Tasmanian psychiatrist – general psychiatrist – he was in Adelaide at the time, and there is evil.

Now the specific money driven diagnosis, deliberate fraud is monumentally widespread where psychiatrists are empowered by all Australian mental health acts to make whimsical, unsupported, capricious specific bogus diagnosis of non-existing mental illness, and cite the following fraud statements with no referenced definition whatsoever. The diagnosed person is a danger to himself or others. The diagnosed person is at risk of deterioration. The diagnosed person does not have the capacity to accept or understand their mental illness, and the person is thought disordered. All of these are unsupported 50 per cent of the time. No evidence, just the statement by the psychiatrist.

The United States American Psychiatric Association says that the predictability rates, even in the most robust system, if you use, you know, particular registered scores to try and predict dangerous to – probability, dangerous to self and others – it's 33 per cent. So it's a 66 per cent failure rate to be able to predict the danger to herself and others. This is the best you can do, even in the most severe criminal cases. So this is – these psychiatrists would be better flipping a coin. They'd get it right at least half the time. These are hideous attacks on people. Now I'm nearly finished.

There are massive amounts of fraud statements all across Australian psychiatry. I'm dealing a case at the moment where a woman is declared she's at a risk of – herself to others, a Victorian VCAT hearing, because she's sending group emails. Now that is spam at the worst. Horrific diagnoses, and the psychiatrists are doing this all the time.

Okay, and no evidence base whatsoever, and The Lancet says that in 50 per cent of diagnoses, there is no evidence base whatsoever for this alleged danger to themselves and others. Now a saltatory metric to describe collapsed productivity is these drugs lead to 26 years' death – rather death 26 years earlier than people not brutalised by psychiatrists. It's utterly puerile to attempt to describe the obvious massive productivity loss, human loss, death and morbidity and sorrow caused by the financially bribery corrupted Australian psychiatry racket.

It's anathema to civil decency and civil society for the productivity commission to recommend any additional psychiatric and – psychiatric and psychiatric nursing to be increased as it has. These profoundly destructive forces are causing pandemic scale death and morbidity with

psychotropic neurotoxins. Now these are the things I think we should have. There's only four or five points.

I think the productivity commission must reveal the incidence of unsupported danger claims, as I said, it's unpredictable, you cannot do it. So if you examine how many times this is failing and you show it to be fraudulent and destructive and killing people, you're doing a great service to the community. You must reveal the coroners omitting neurotoxin deaths in causes of death. You must research neurotoxins deaths and the real statistics, in other words, not jumping out of a building or being hit by a car if it's a suicide. You must show the related connection to the psychotropic drugs.

You must rescind more psychiatric nurses – recommendation you made, because it's only going to make things worse. Now you must research the 115 per cent of Victoria versus New South Wales fraud of forced orders in Victoria to New South Wales.

MS ABRAMSON: I'm sure you've brought that to the attention of the Royal Commission.

MR FLOYD: Yes, but I'm saying you must – these are my points, I think you must research these things. Due to mass deaths, research recommended to criminal psychiatric praxis legislation. In other words, if some of these things are shown to be pure fraud and lies, I think you should be very active in going to the root of these and making some contribution to productivity in Australia.

MS ABRAMSON: Mr Floyd, thank you for bringing your presentation to us today. I will read what you put in to us. Harvey, did you have any questions?

PROF WHITEFORD: No.

MS ABRAMSON: No, thank you.

MR FLOYD: Thank you.

MS ABRAMSON: Thank you very much. Could I now ask if there's anybody who would like to give evidence today who's not on our list? We're happy – we've got a little bit of time to hear from you, so is there anyone who would like to speak? No, in that case, can I thank you all for your presence today. We've had a bit of trying technology, so thank you for persevering. Can I now adjourn the commission's hearings until Adelaide next year, and can I thank the commission staff for their hard work today, thank you.

MATTER ADJOURNED



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

PROF STEPHEN KING, COMMISSIONER
MS JULIE ABRAMSON, COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

AT THE PLAYFORD ADELAIDE HOTEL, 120 NORTH TERRACE, ADELAIDE
ON WEDNESDAY 5 FEBRUARY 2020

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PROF KING: Good morning, all. Welcome to the public hearings following the release of our draft report for the Productivity Commission's inquiry into improving mental health in Australia. My name is Stephen King and I am the presiding commissioner on this inquiry. My fellow commissioner here with me today is Julie Abramson. Before we begin today, I would like to acknowledge the traditional custodians of the land on which we meet, the Ghana people, and pay respect to elders past, present and emerging, and I extend this respect to all Aboriginal and Torres Strait Islander peoples in attendance today.

The purpose of this round of hearings is to facilitate public scrutiny of the Commission's work and to receive comments and feedback on the draft report. This hearing in Adelaide is one of many that we're having around Australia in all states and territories in both capital cities and regional areas. We will then be working towards submitting our final report to the government in May, having considered all the evidence presented at the hearings and in submissions as well as other informal discussions. Participants and those who have registered their interest in the inquiry will automatically be advised of the final report's release by government, which may be up to 25 Parliamentary sitting days after completion.

We like to conduct the hearings in a fairly informal manner. I'd like to remind participants, however, that the legislation does dictate how these hearings can be conducted. For that reason, a full transcript is taken of the hearing, and so comments cannot be made from the floor. They simply don't get on the transcript. The transcript taken today will be made available to participants and will be available from the Commission's website following the hearings. Now, the microphones that you have here are purely for the purpose of the transcript, so if I could ask people who are providing evidence before the hearing today - if they're able to speak up, that would be fantastic. Otherwise the people down the back have got a ways to move forward. Also, just a reminder, make sure your mobile phones are on silent.

Participants are not required to make 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 not defamatory of other parties. You are all free to enter and exit the room as you want. If at any time anyone needs a quiet space, please feel free to exit the hearing. If at any time you feel distressed, please approach one of our staff, who will assist you, and we have Lawson - - -

MS ABRAMSON: Lisa and Katie.

PROF KING: Lisa and Katie. In the unlikely event of an emergency requiring evacuation of this building - Lawson to advise on the day.

LAWSON: Downstairs and evacuate through the revolving door.

PROF KING: Fantastic.

MS ABRAMSON: He's much better at that than we are, Stephen. We never get the evacuation right.

PROF KING: I think evacuating through the revolving door in the lobby is a really bad idea.

MS ABRAMSON: We can comfort the participants. We've never had to do this.

PROF KING: Our first participant today is Philip Armstrong. So Philip, welcome. If you're able to state for the transcript your name and the organisation you represent and any opening remarks that you'd like to make.

DR ARMSTRONG: Thank you. Thank you very much for inviting me to speak at the Commission. My name is Philip Armstrong. I am the CEO of the Australian Counselling Association. ACA is the peak body for counsellors in Australia, with close to 6,000 registered counsellors and members. ACA does work closely with other organisations within the counselling industry. We work very closely with another organisation called Psychotherapy and Counselling Federation of Australia whom we are a partner organisation of for the Australian Register of Counselling and Psychotherapists, so ARCAP. If you hear me use the word ARCAP, that's what I'm talking about.

So ACA welcomes the Productivity Commission's draft report into mental health and we applaud its focus on system reform, early intervention and prevention, the cross-easement coordination and supports of mental illness and its attention to creating reforms centred around the needs of customers or consumers, sorry, and their carers. To ease my presentation and save confusion, when I refer to the term "counsellor", this term also incorporates the term "psychotherapist". ACA has a longstanding protocol of accepting that they are both one and the same. There is – the most significant difference between the two is the obvious: it's the spelling. So ACA members may refer to themselves as psychotherapists or counsellors. However, neither title esteems to reflect any superiority in training or abilities to work with mental health clients. So just to clarify that when I say "counsellor", I'm not neglecting psychotherapists. I just want to keep this as concise as possible. Also, when I refer to the term counsellor outside of any research or quotes I may make, what I am referring to is an ACA registered counsellor, which is very important, okay. So we're defining who the counsellors are.

Okay. So ACA contributed to the ARCAP's submission, which - I would hope that has been read. So I'll attempt not to double up on any information that you would already be aware of from that submission. Since the release of the draft report, many counsellors have had the opportunity to provide evidence at the Commission as part of the hearings. I'm pretty sure I'm not the first one that you guys would have heard.

MS ABRAMSON: No, we've had a number of your colleagues.

DR ARMSTRONG: That's great. So these opportunities have provided invaluable feedback to me and helped inform my address today. What I've done is I've attempted to

read as many transcripts as I possibly can that have included counsellors - also by some psychiatrists and psychologists – to help me to try to – hopefully give me some new information, as opposed to going over old information. But again, from the questions I've read I also ran into some confusion. So hopefully I can clarify any of that confusion while we're here as well. So the draft – while the draft report recognises counsellors and psychotherapists as a self-regulated allied health profession, it does not adequately acknowledge the qualifications and skills of counsellors or their potential to positively contribute to the mental health outcomes of Australians through providing and performing services within and outside the health sector, and I'll be a little bit more specific on that issue later.

First of all, what I want to do is let's just have a look at who are registered counsellors? Who are we? Okay, so everybody understands who registered counsellors are. So the profile of an average ACA registered counsellor is someone between the ages of 40 and 60 who is usually on a second or third career change. 75 per cent of our members are female. A large proportion of our members have grown families or teenaged children. The average member will be someone who most likely already holds a formal qualification from a past career, and we had - a significant amount of our members are past teachers, social workers, medical doctors and nurses. Other members come from professions such as the police service, military, ministries, belief systems and stay-at-home mums whose children have left the nest and they've chosen to come into the workforce. There is a great percentage of refugees and immigrants also coming into the profession. There are a significant amount of multilingual members, particularly from Asia, South America and Africa, which again reflects the amount of immigrants and refugees that are now coming into the industry, and a lot of them are coming in with overseas qualifications and we do find a lot of them to be very good. In comparison with Australian qualifications, a lot of them are on par, which we do find interesting. So a proportion of our members also have lived experience of mental illness.

So many people ask, what is the difference between a counsellor, psychologist, psychiatrist and social worker? Most people will answer with an answer that is based on qualifications and a registration process, as no doubt you have heard. But I think people actually miss a more important difference. What are – the significant difference is the qualities that counsellors bring to mental health that others do not. Age is one. The average counsellor, when they graduate, is 40 to 45 years old, in comparison to the average psychologist and social worker, who is approximately 26, and psychiatrists, who are around about 28, give or take a year. Another significant difference is, all the disciplines – out of all the disciplines, counselling is the only one where the average new graduate already has significant work and life experience prior to graduation. They can speak from a perspective that most new graduates in any other profession cannot. They are able to get this from the get-go. They legitimately understand life's challenges beyond being a youth and studying. They can draw on real-life experiences, not just theory.

Having 20 or more years of life experience before coming into the profession also ensures counsellors are resilient. Due to their life experience, counsellors are reticent about

making a diagnosis and prefer to simply work with the human being in front of them, listening to their story, which in many cases is complex with many layers, before determining if a diagnosis is necessary or, in fact, in the client's interest. This should not be misinterpreted to mean that counsellors are not qualified or trained to make a diagnosis. A common myth held within mental health, that counsellors are not qualified to do that. Many are.

What does "registered" mean? So we'll just clarify what does "registered" mean when I say "ACA registered counsellors". So each member of ACA – and this goes for ARCAP in general. So each member of ACA has been able to verify through formal documentation that they meet ACA training standards. They undertake regular clinical supervision, undertake regular professional development, and adhere to a stringent code of practice which incorporates our complaints mechanisms. Our members also have to adhere to legislative requirements depending on the nature of their position. ACA requirements are rigorous. All documents must be verified by a JP against their originals. ACA membership documents are audited by an external auditor independent of ACA each year to meet legislative requirements in regards to private health funds and the legislation that comes through the private health funds. Once a member meets all requirements, they are placed on the ARCAP register. We – to give you some perspective, we probably knock back, on a weekly basis – we – right now, we're averaging around about 100 new members a month. We average around about five or six applications a week from psychologists and social workers who do not meet our standards and therefore we refuse them membership. So I think that's an important thing to remember, too - that simply being a psychologist or social worker does not meet ACA membership requirements.

So one of the questions I did notice was when you talk about research - there's been a lot of statements made around research. I'll clarify that for you. So over the last 30 years, hundreds of mental analyses have been conducted on the efficacy of psychotherapy and counselling, and what the summaries of these meta-analyses suggest is average effect size for counselling compared with no treatment control is somewhere around .75 to .85 of a Cohen's d scale. For those not familiar with the research, the Cohen's d scale is used a lot within mental health to measure outcomes. To give you a perspective - so we're saying that the outcomes are .75 to .85 - .2 on the Cohen's scale is small, .5 is medium, .8 is large. So in other words, counselling has a large effect – substantially larger than many medical or surgical procedures, which have an overall effect size of .5. I have all the references for these statements, should you require them. Be a bit silly to make them without the references, wouldn't it?

So summarising 28 clinical trials, Hansom found that around 60 per cent of clients in psychotherapy improved to an extent that was clinically significant. Studies of therapy in clinically representative real world – when we talk about being clinically representative, that's just a term used in mental health for "real world". So studies of therapy in real world conditions generally indicate that it's highly effective. For instance, within a U.K. primary care setting, Styles and colleagues in 2008 found that around 58 per cent of counselling and psychotherapy clients achieved reliable and clinical improvements. So

what about measuring? Okay. Studies using routine outcome measures, such as the clinical outcomes for routine evaluation, as we call CORE, which is used primarily – it's very heavily used in Europe, particularly in the U.K. We - as a counselling association, we're trying to get it introduced into Australia, while we are aware that there are some NGOs in Australia who are using CORE. So CORE have reported reliable post-intervention improvements for counselling in three quarters of clients and demonstrated persons stated counselling to be an effective intervention for clients with common medical health problems.

Another interesting point to note in the research findings is that they reflect that counsellors are more highly accepted by clients than either psychologists or psychiatrists, and that was an Australian study done on the Gold Coast by Sharp, (indistinct), and they are also seen to be more approachable and empathetic, said the study by Sharp. There is a strong evidence base that providing services according to client preference improves therapy outcomes, and I think your report actually clearly does indicate that. So I'm just repeating what we do know there, and the reason why I put that in there is I think that it's very important to put that in context with the research that I'm talking about, that counsellors are not only effective but a part of the system, and from the research - although it's not large, like most mental health research – there is an indication that in the real world, the consumer is – much prefers to see a counsellor than anyone else as a first option, and yet that is not the opportunity that they're given through the MBS in Australia. We're not even an option, even though we are considered to be a first choice. So access is significant.

So what I'm going to do for now, I just want to quickly go over courses. So what qualifies a counsellor to be a counsellor from the accreditation process?

PROF KING: I'm just wary of the time, because we would like to ask you some questions as well.

DR ARMSTRONG: Absolutely.

PROF KING: So – I mean in the sense, courses and so on, we are able to look up ourselves through university and college websites.

DR ARMSTRONG: I think – well, the reason why I brought that up is there is a difference. ACA has its own accreditation systems, so just because a course is out there – I remember one of the comments that was made by – I think it was a psychiatrist in Melbourne, "Anyone can train to be a counsellor because they can do an online course". Well, that's not correct if you want to be a registered counsellor. That's why I'm just following that up.

PROF KING: I understand.

DR ARMSTRONG: Thank you. You saved me a bit of work there. Okay, and to – just to help you understand, ACA has a level system for membership. So we have level 1, 2,

3 and 4 for practicing counsellors. So I'll just quickly explain that. So level 1 are diploma graduates, and that was why, actually, the thing about the accreditation is there are only four diplomas on the training pages that ACA accredits. So you can't just do a diploma, either, and that's because of the – mainly it's because we don't just accept online training. We have specific training standards. So there are only three diplomas we actually accredit through the Association. So our level 2 members are either Bachelor degree graduates, so new graduates, or diploma graduates with more than two years' supervised practice. Level 3 are members with either a Bachelor's degree or a Master's degree who have a minimum three years' post-qualification with a minimum of 75 hours' supervised practice and 750 hours' required contact time. Level 4 requires six years' post-qualification with a minimum of 100 hours of supervised practice and a minimum 1,000 client contact hours.

If you actually want to do a mapping exercise, our level 3 and 4 requirements are higher than that which current social workers and mental health nurses require to register for Medicare provider numbers. I think that's an important thing to remember. I don't think we need to prove that we are equivalent to current providers. It's already there. Level 4 is higher than the requirements for a general psychologist, with level 3 being equivalent or higher depending on the psychologist's pathway, which you would be aware there is – I can't talk for psychologists. There are several pathways. My wife's a psychologist, so I have a working knowledge, but I'm not here to talk about psychologists, and none of this is meant to be a criticism of any other discipline. I'm simply pointing out the differences.

PROF KING: I understand.

DR ARMSTRONG: The stepped care model – and what I've brought for you, just to help you with this – there's a little bit of a map there, because I did notice one of the questions - - -

PROF KING: Thank you, sorry – just for the transcript, we've been handed just a one-page document.

DR ARMSTRONG: So I noticed on one of the questions the Commission did ask was how does – how do we see counselling fitting into the stepped care model, which is a very important question. So how do we see it fitting in? Looking at the diagram I've given you, the way we see it is that counsellors absolutely fit in and I think what hasn't been made clear to the Commission is that we fit in all places of stepped care. Unfortunately, some people have just spoken about counsellors coming into early intervention or primary care. That doesn't do counsellors' qualifications and the use of the training they've done justice. What we see is that within stepped care, primary care service would be level 1, 2 and 3 members; step 2, which is low-intensity service, level 2, 3 and 4; and step 3, high-intensity service, we see level 3 and 4; and complex treatment service, we see 3 and 4. Just to clarify for the Commission, when we talk about levels 3 and 4, we're not talking about individual counsellors practicing at those levels independently. We're talking about counsellors being part of multidisciplinary teams, so working with psychiatrists, clinical psychologists and such. Certainly, we wouldn't be suggesting levels 3 and 4 as

independent practice, and I think most people who work within the high-intensity and complex do work within interdisciplinary teams in any case.

What I'd like to do, though, is - just to demonstrate what I'm saying, is read a letter that we have here. Now, obviously I can't identify this person. But this is from the North Melbourne – North Western Melbourne Primary Health Network. Now, I don't know if the Commission understands the PHNs, but they're a - what we call lead - - -

MS ABRAMSON: Yes, you can take it that we do.

DR ARMSTRONG: Absolutely great. So you'll be aware, then, that North Western Melbourne is a lead PHN. So people are taking what they do as being – works. Okay, so let me just read this.

I wish to advise –

and I can't mention his name -

– has been contracted by the North Western Melbourne Primary Health Network since 2016 to deliver a range of mental health services including targeted psychological support services, focused psychological strategies, suicide prevention services, counselling, intensive support services, and coordinate care for people for people with severe and complex mental health needs. (This person) holds an independent contract with the PHN and is subcontracted by psychiatrists in the delivery of intensive support services. During 2018/19, (the gentleman) delivered almost 500 hours of service interventions, including approximately 100 hours of direct counselling through (the organisation). He regularly attends mental health provider forums and has satisfactorily met our clinical governance requirements refine reviews, which are conducted annually. We have not identified any issues warranting concern either from client feedback or operational.

That is a letter from a level 3 member of ACA, and the reason I think it's important that this letter be read out to mention is to reflect that we are already doing the work. We are already employed within PHNs and contractors and tenders to be working at the high-intensity and complex treatment service level, but also within, obviously, step 1 and step 2. But we are already doing it. It's an irony that we have to sit here – and certainly this is no criticism of the Commission, but it's an irony we have to sit here and try to justify to the world why we should be allowed into things such as the MBS when we are doing work that is above people that are already registered and given access to broader numbers. We shouldn't have to be continually proving who we are, what we are and how we work when the industry itself already recognises it. As I said, that's a level 3 member of ACA who is working within – actually doing the work that we're now asking everybody to recognise that we're capable of doing. We're already doing it. That is one of many, many of our members who are working within the system at these levels.

So this brings me to my next point: outcomes. So registered counsellors have equivalent competency skills and experience in delivering evidence-based psychological strategies to other allied health professionals and are already eligible to provide MBS-funded services, and I've just given you an example. This gentleman would – if he was a psychologist would be standing on his head getting into – an MBS provider number. It would be a matter – just an administration point. So there's no research that reflects any one type of therapist, being a psychiatrist, psychologist, social worker or counsellor, who gets purer results or greater efficacy than the others. It would be a fallacy, or a myth, for any of us – including counsellors – to suggest that we get better outcomes. The research just simply does not support that intention. But the research is very strong that actually, we get equivalent outcomes. So we do get outcomes, but they're generally equivalent to each other.

A study by King and colleagues in which non-directive counselling as practiced by bona fide accredited counsellors – these were in England – was compared with CBT as delivered by qualified psychologists showed an almost identical reduction in levels of depression across two therapies. This study reflected the same outcomes from another study in the late '80s by the U.S. National Institute of Mental Health Treatment of Depression Collaborative Research Program, which is considered even now to be the most methodically sophisticated study ever done. The large majority of research not only reflects that not one discipline is superior in getting positive outcomes, the process of reaching this conclusion has also shown that longer periods of formal training, such as mandated additional graduate qualifications, also have no impact on outcomes, which is something else that tends to be overlooked when you hear some people who go on and on and on about the more qualifications you have, the better practitioner you are. The research just doesn't support it. Obviously, the research does support that you need qualifications and training, but there is a limit.

So what works in therapy? So research from (indistinct) consistently demonstrates outcomes of therapy primarily relies on – and this is why my previous statement is so important, because what research has found is that the – a lot of outcomes are more dependent on the quality of the therapeutical relationship, the strengths of the therapeutical alliance, and the therapist's level of empathy, which is something that is taught to all psychologists, psychiatrists, counsellors and social workers. It is not taught independently to simply one discipline, which is why, probably, we all get equivalent outcomes.

One area that we do find – and again, identified by the Commission – where there are significant issues and we know counsellors could absolutely have a significant positive impact is in rural and regional areas. There are significant chokepoints all around Australia where patients requiring mental health services under the MBS are placed on long waiting lists. For example, patient waiting times in days to commence treatment under Better Access initiative in the Hunter Region can be up to 25 days. There's currently over 200 registered counsellors in the Hunter Region who are available but can't be used. That would make a significant difference to those waiting lists if those counsellors were able to support those clients. There's – okay, covered that. There's also – I mean, there's Armadale – we've got a whole raft of regional - and you'll be aware - of regional areas and rural areas where there are significant waiting lists. In just about all of them, there are

counsellors who would be eligible for MBS rebates should it be – happen under the models that we talk about who would be able to support those patients.

So young people in rural areas experience differential access to Medicare-funded services such as psychological treatment. They experience significant wait times to access psychological counselling, averaging six days to be assessed with a maximum daily wait time of 23 days and a commence-treatment time averaging 15 days with a maximum daily wait of 41 days. Now, that's from the HNECC data. These are just three examples of hundreds where counsellors are being underutilised at the unnecessary expense of mental health consumers. There's a lot of – and also anecdotal evidence that we're aware of, and there's one I remember going back two years in the Hunter Valley where – as I said, this is anecdotal – where people have actually suicided on waiting lists because they've been waiting for services, and to think that there's over 200 counsellors qualified to have helped those people – that's just a tragedy. It should never have happened. So it's a fault within the system.

PROF KING: Very keen to follow up with some questions on that, by the way, so – but I'm very wary of the time.

DR ARMSTRONG: Okay, I'll cut this down for you. So what I've also noticed that you asked for, obviously – I won't go too much on MBS. One thing I'll state is ACA and ARCAP, we are very aware a) that the MBS rebate is not a panacea for counsellors. I know there were a lot of very frustrated and desperate counsellors who made submissions and who you heard speak and a lot of them did talk about the financial issues. But that's simply because of the frustration where - when you're receiving phone calls every day – not just once or twice but every day – from people that are desperate to receive counselling because they're on waiting lists and you have to tell them you can't help them or you have to offer, you know, pro bono services, which is not – you know, the Australian psyche is very much “fair day's pay for a fair day's work”. So, like, counsellors, out of all mental health professionals, should be expected to work for nothing like that? No, particularly after spending a significant amount of time getting qualifications and the registration process. So a lot of that comes from that. So I won't go too much into MBS. You would have heard all about the MBS. Let's have a look outside of MBS.

One of the things that we have thought about is that maybe it would be an idea if the government was to develop a funding stream to have counsellors embedded within GP practices to work with subacute patients. That would be an area where we could certainly – particularly those even with acute services, complex services, we can manage them whilst their waiting for – to go to acute services. We know there's a shortage for psychiatrists in Australia and certainly - counsellors working within a GP system can certainly manage them to ensure they don't suicide, help them with whatever medication they're on, and to be able to manage them until they can see the psychiatrist.

MS ABRAMSON: Sorry, I just wanted to ask a question. With that model that you just proposed, what prevents it happening at the moment? Because you spoke about the North

Western PHN in Melbourne and they're already doing that. So if it's not an argument about MBS, which – we understand that argument, why wouldn't that happen in any event?

PROF KING: The PHNs have got the – what was the mental health nurse in GP clinics - - -

MS ABRAMSON: That's right, the funding. Yes.

PROF KING: - - - and they could use that for counsellors.

DR ARMSTRONG: Because there is a resistance within - certain PHNs tend to be run – how do I be politically correct on this one? They tend to be monopolised by certain - - -

MS ABRAMSON: You just think there's a cultural – what you're saying is there's a cultural issue?

PROF KING: It's an issue for PHNs.

DR ARMSTRONG: In some PHNs, yes. Absolutely. We have rung up and contacted every PHN. Some won't speak to us, some are very opening and they – like the North Western Melbourne, and some are just ambivalent, and again, a lot of that's to do with culture within those PHNs. Certainly the research doesn't seem to matter, particularly the tendering services. A lot of the tenders that go out are written in such a way as they claim to be balanced and open, but if you actually read the writing, they then talk about “one must be registered with a certain college”, which then just cuts out 95 per cent of applicants. So you know, look, you're not even given a chance to apply or be assessed on your abilities, let alone anything else, simply because you're not a member of a certain college, which is just ridiculous. It's biased. So that's what does – so a recommendation from the Commission would go a long way into helping support us to get that model off the ground.

MS ABRAMSON: See, I would say to you that in our model, we've proposed two types of - the rebuild and the renovate model. But in our regional commissioning authorities, it would be our expectation that they could commission the sort of services that you're talking about, just like the PHN. But what you're saying to us is that there is actually a cultural issue as well. So even though they can do it – leave aside – MBS to one side. Even though they can do it, they're not doing it, and the reasons that you suspect for that is, like, a culture around who can help whom at what time.

DR ARMSTRONG: Absolutely. That is – there's also a (indistinct) issue that comes into it. A lot of these services – and one I was going to talk about is even when we look at employee assistance programs, and a lot of contractors – what they do is they'll put out a contract for a mental health professional to deliver a service on the basis that that provider has an MBS provider number, and what they'll do is limit the funding to maybe three sessions and then what they'll say is, well, after those three sessions, to ensure there's continuity within the counselling process – because we know the majority of people need far more than three sessions to get any sort of positive outcome – we'll then go on to MBS

Better Access to keep the cost down for the clients. Well, the fact is, we don't have access to Better Access. So as soon as they put that in the contract, counsellors are out and so are a lot of other mental health workers, on top of the fact that they then put "got to be a member of a certain college". So it's cultural, but it's then the – what is also added to the obstacles that are put in our way is they then say you must have an MBS provider number so you can continue to deliver your service through. So it's not double-dipping, because that's illegal, but it's a pretty - - -

MS ABRAMSON: No, no. It's a business model. I understand.

DR ARMSTRONG: Yes. It's legal and it makes sense. But what it does is it prevents the counsellors from coming into the system. So that's the other obstacle that comes in with – there. So unfortunately, MBS does have peripheral impacts on us because that's how a lot of organisations work. Even a lot of NGOs will subcontract mental health workers on the basis they have provider numbers, and if you go through the employment ads, you'll see it's quite clear in a lot of them. So again, counsellors are out of the picture.

MS ABRAMSON: Dr Armstrong, you mentioned the Hunter Region and you said that counsellors can't be used, and yet – you mentioned a quite tragic circumstance there. Is that because of the arrangements of that local PHN?

DR ARMSTRONG: Yes. Also the fact that we can't – because what a lot of - obviously, a lot of people – the Hunter Valley people, in those days, just didn't want to hear it. A lot of people there relied on the Better Access system to get entry to mental health services because those counsellors don't have access to it and they can't offer their services.

PROF KING: Just – so culture and, as you said, the issue of Medicare provider numbers allow you access to a certain pool of funds and allows a PHN or another commissioning agency to (indistinct), if I can put it that way. Our models that we recommend explicitly avoid that problem, particularly the rebuild one, by saying, well, if a – you know, nominally, any access to Medicare funds is a budget item for the commissioning authority. So if we remove the dollar issue – so if our recommendation is accepted there, what can you do about – what should we be recommending to do about culture? Because we've said we fixed one of the problems – you can see our recommendation does, but that still leads to culture - - -

DR ARMSTRONG: But – it's an interesting issue. I've been in the industry for over two decades, so I was in the industry before MBS. So in 2006 when the Liberal government introduced it - and pretty much it was introduced as a last-minute way of getting votes, let's be honest. It was – obviously there were good intentions behind it, but it was a last-minute idea and we weren't consulted during that process. So counsellors were left off, but prior to that, I had a private practice and we would be – my private practice and most counselling - prior to 2006, GPs would refer to us before psychologists. A lot of that was a cost issue – counsellors were cheaper – but before that, there was not an issue – before that, we had – we worked in ATAPS, which we've now been taken out of although we worked in it for over 10 years. So there's no – and there was no reason we were taken out of it. As in, lack

of effect or anything else. So prior to 2006, the medical system had no issues with using counsellors. We've spoken to – we had a meeting with the rural – the office of the rural GPs in Brisbane a couple of weeks ago and they said they would love counsellors to come back into the system, and so would the GPs because it gives them better options and greater choice when doing their referrals. So I don't think they would – if counsellors came back into the system, there are a lot of people within the system – and I've read some of the transcripts where you've had psychiatrists, psychologists and social workers who've all said they can't understand why we're not in the system. So there is also a – still a strong positive attitude towards counselling within the system and I think that would certainly go a long way to doing it, would be the positivity that comes back into access and choice. But also - I think it would be up to organisations like the Australian Counselling Association to develop public education programs, but also we would have to look at the PHNs and do professional development workshops for GPs and for mental health providers in all government organisations. That would be, certainly, a job that ACA would have to take on as a peak body. That's our responsibility. So I think that could quite easily be done over a period of, you know, 12 to 24 months, just educating. But also – we'd also be then hitting up the government for funding to do television advertising, whatever.

PROF KING: But it sounds like if we're able to fix up the dollar incentives, that would go a long way.

DR ARMSTRONG: Absolutely. I mean, we used to work with divisions of GPs before it became the PHNs.

PROF KING: I'm really conscious of the time, so any final comments that you want to make, and then I'll just check if we've got any more issues that we want to - - -

DR ARMSTRONG: Two final comments. One is the GST issue. A recommendation to have counsellors be made exempt from GST, that's simply a point of legislation and it's a ridiculous legislation in the sense that, you know, counsellors have to charge GST where psychologists, social workers and the rest - who are providing counselling services, mind you – don't have to pay GST. The issue – or the reason why a counsellor has to pay GST is because GST is not payable on a GP-referred program. So a GP can't do up a healthcare plan for a counsellor.

MS ABRAMSON: Can I just say, Dr Armstrong, it may be even more difficult to change the GST system than the MBS system. I speak with experience here.

DR ARMSTRONG: We've had three goes at it. I believe there's only one that's ever been successful and that was women's healthcare products. It's been the only one that's been successful and I understand that, and that's not an important one. But I just wanted to reflect to the Commission that we're looking outside the MBS box. There are other things that need to be done. The – one thing is, I mean, we have – I've also, maybe, picked up, correctly or incorrectly - there seems to be a concern that - if the Commission was to make recommendations that they probably wouldn't be taken seriously because of the financial issues, I think.

We have an economic argument which we've made on several occasions. I won't go through it today. But I did want to just make it known that I've had significant meetings with the minister's office and minister's advisors and they have been very clear that should a recommendation – and they have encouraged us, which is why we've had so many counsellors here, too – we have been encouraged to get recommendation from the Commission that counsellors go into MBS and the Better Access initiative and – plus recommendations that we won't get the money – and the minister's office will absolutely take them seriously.

The Minister is very much in our court in that he would like to see counsellors come into the system, particularly from a departmental perspective; that there should be more counsellors on round tables and the such, and a lot of the reasons why they're not is because a lot of them require people from the MBS system to be advising. So from the Minister's office, my perspective from what he's told me directly, this is Minister - the Honourable Greg Hunt, he would support a recommendation. Obviously, he can't make them actually happen, but he would certainly be in our court to try to make that happen.

So it is serious, and you know, I think it's important that the Commission realises that it would be taken seriously, and we take it seriously, and so we would strongly - - -

PROF KING: I hope all our recommendations are taken seriously, so yes. (Indistinct).

MS ABRAMSON: No, no, I asked just as we were going along.

PROF KING: I just wanted to get from you - and apologies, because unfortunately with the number of submissions that we do go through, I don't think I've seen the data on the - I don't think I've seen the data on the geographical spread of counsellors. I don't know if you've given that. If you haven't, that would be really useful data to give

DR ARMSTRONG: We will, absolutely.

PROF KING: Because obviously issues that you mention, with regional and remote. Also understanding some more about, if I can call it - and obviously, you can't answer these now - but measurements of spare capacity of counsellors. And the reason is that when we've had some of our remote hearings and we've talked to some of your members, and they've said, well, you know, it would be great if we're under (indistinct) yes. Great under the MBS. But then when asked, well, but there's a shortage of counselling services here, how much spare capacity? All my books are full.

And obviously that creates an issue if you're saying, well, I'm working to capacity but counsellors moving onto the MBS will increase capacity, and we need to - and please feel free to put in extra submissions.

DR ARMSTRONG: The average counsellor wouldn't be at capacity, and over 75, we've already done - over 75 per cent of ACA registered counsellors were outside of major CBDs.

MS ABRAMSON: We're really, really interested in this region and rural, and where your counsellors are.

PROF KING: And the other one, as you mentioned, CALD communities and multilingual.

MS ABRAMSON: Yes.

PROF KING: And again, not for now, but if you're able to give us more details on that, that really would be excellent.

DR ARMSTRONG: Yes, absolutely, and we have significant Korean, Chinese, and we actually have a Muslim group down in Melbourne. (Indistinct).

PROF KING: Again, if you're able to give us - you know, it doesn't have to be a complete - - -

MS ABRAMSON: And in the absence of our Assistant Commissioner, we're saying we don't mind late submissions on that.

DR ARMSTRONG: Okay. All right then.

MS ABRAMSON: No, that would be really helpful.

PROF KING: Does that mean we're going to get a text in two minutes - - -

MS ABRAMSON: Probably. Probably we will.

PROF KING: - - - saying (indistinct).

MS ABRAMSON: We will, we will.

PROF KING: All right. Thank you.

MS ABRAMSON: It would be really - one thing I was just going to ask is, with the CALD communities, it's an issue where we're quite concerned about how we can provide services that are both language and culturally appropriate. So the worked examples of how some of those - the Korean, the Chinese, that would be really helpful. The other issue that would be helpful for us is, there are a whole range of different cultural groups in Australia, so one of our difficulties is, well what - where would you start? What sort of communities? So the work that's already been done would be very interesting to us. Thank you.

PROF KING: And getting numbers on the threads.

MS ABRAMSON: Yes.

PROF KING: Where the services are remote and that sort of thing.

MS ABRAMSON: Thank you.

PROF KING: Thank you very much, Dr Armstrong.

MS ABRAMSON: Thank you. They clap here. They didn't clap in Launceston.

PROF KING: They didn't clap in most places.

MS ABRAMSON: But they clap when we shut up probably.

PROF KING: That's important. Our next presenter is Julianne Martin.

MS ABRAMSON: No. Julianne is with the Australian - it's Mr - - -

PROF KING: Okay. Bob Riessen. Sorry, okay. So our next presenter is Bob Riessen.

MS ABRAMSON: Thank you.

PROF KING: And again, just for the transcript, because obviously the transcript can't see papers, we've just been handed a two-page document by Dr Riessen, and if you're just able to state your name, any organisation you're representing, and any comments.

DR RIESSEN: Okay. Dr Bob Riessen. I've been a retired GP. I've been advocating in mental health for 45 years, not only in practice, but running meetings for GPs, attending specialist meetings, running a show on the ABC with Peter Goers, and in retirement, still active re advocating for mental health.

MS ABRAMSON: So not so much in retirement.

DR RIESSEN: Yes, so I've presented - I've written a submission and papers to the Productivity Commission and - but I've summarised them, because I want to tackle it, because I realised in listening to your transcript, in listening to the Mental Health Commission's communications paper to the World Health Organisation, and I know that you must be full bottle on information that's concerning people around mental health in Australia.

And so I'm tackling from - and the idea came from the importance of observation. Max Bazerman in his book, The Power of Noticing, said what every good leader have. Described all the facts and figures that were present to them before September 11 and before the world Global Financial Crisis in 2008, and he said, all this we could have acted on, but didn't. So I'm looking back now at the last few decades of mental health in Australia and looking what we could have acted on, and what - you know, just what's gone wrong, perhaps.

So for 45 years, I have observed increasing mental health, mental illness, and decreasing mental wellbeing in the community, and it's just as though we're not meeting the consumers or carers demands, or society demands for equity and human rights. Secondly, if we look at the cause of why we're all here, and why we're discussing mental illness, if it's our genes that are the bullets in our personal guns, as it were, it's lifestyle changes - and that's the paper that I put on your desk - it's lifestyle changes that pull the triggers and cause the damage.

So, I don't think we've done enough to look at these lifestyles factors at the first time of impact, which I think is at conception. There are even studies now done in preconception that look at epigenetics and look at how we can modify genetic behaviour. Society, I think, and these are my observations, has changed at a rate where healthy mental health or wellbeing adaption has failed to keep up. News and information, for instance, bombards our minds at ever increasing in frequency and intrusiveness, and therefore influences our lifestyles in unhealthy ways. Just one quickly, (indistinct).

It influences other things in our cognition, our behaviour, and in our moods. So some of the result of these lifestyle stressors, I think, have shown other unhealthy changes in our society. There seems to be less respect, less individual responsibility, less resilience - that's the ability to pick you up - yourself up from minor setbacks. And, of course, they all have secondary effects on other people. I don't think there is one area in life, from conception on, that good mental wellbeing doesn't have an impact, and I think the costs of people not being at the top of their game extend right over the full period of our lives.

The current medical health system, for my mind, is heavily weighted towards those businesses, research professional entities, that benefits from influencing the system, and I'll talk more about the implications of the previous speaker later. The cost of poor mental wellbeing affects this country enormously, I think, and I - but it's only the tip of the iceberg. Below the surface, we have this swirling ocean of people who are underperforming, who are perhaps to have other symptoms, and I think from an economic point of view, if every - if you could imagine everyone performing at their best, how much better this country would be.

MS ABRAMSON: We put some numbers on that. Productivity numbers.

DR RIESSEN: Interesting. I could give some examples that would give an indication of just the economic intrusion into individual's lives and (indistinct) to other areas. I don't know how much time we've got. So a lady in her mid-forties attended her local state mental health clinic. She had a blood test. She said, 'I'm down to my last tablet.' And she said, 'Oh, look, there's no doctor here.' 'Well, come back tomorrow.' So she had to come back to that clinic the next day, got the results of the blood tests. 'Oh, now I've run out of tablets. Oh, well, where's the doctor? Oh, there's no doctor.'

Script wasn't ready. 'Oh, look, go to your chemist and we'll fax it through.' She went the chemist, wanted an hour and a half, and still nothing. The chemist said, 'I've got to close,

I've got to close.' Well, he rang the medical clinic; no service. He had the client - this girl had panicked, and she was - received inappropriate medication from her family, and you know, and it aggravated her illness. I mean, there are numerous cases. I could go on and entertain - - -

PROF KING: (Indistinct) these scripts will get around that sort of problem, and that legislation's been put through already, I think.

DR RIESSEN: Yes, yes.

PROF KING: Federal parliament.

DR RIESSEN: Yes.

PROF KING: So I gather this (indistinct) another hat on - - -

MS ABRAMSON: Yes, Stephen's pharmacy inquiry intrudes it.

DR RIESSEN: Well, just a quick point pharmacy. Yes, pharmacies are intruding the realm of general practice, as it were, and - but of course, what are pharmacies? They sell. They don't mind how they do it, but they get people in the shop, they get - like bums on seats, they get people in store. They can sell them other things. So I can understand - - -

PROF KING: Including homeopathy, which we won't go down that argument.

DR RIESSEN: Yes. I can see the - - -

MS ABRAMSON: Stephen, we do not want submission from the pharmacists.

DR RIESSEN: I can see the energy behind all their - all these things, but, you know, there's a cost to it.

PROF KING: Yes.

DR RIESSEN: Anyway, I won't go into all the examples that I could have, but they reflect on not only state mental health services, on training of GPs in emergency departments, they look at psychiatrists who are already seeing people, and yet they still suicide. I could go on and on and on. There are anomalies in the system that we, you know, need to address, but that may be not your job from the economic point of view.

But, getting back to the genetics and lifestyle, that paper I gave you by Charles Nemeroff that came out in January from Austin in Texas looks at what are the most significant factors that affect mental health and its evolution, and I'm - and I agree with it. And this what my submissions have been about. It's about seeing if there is some way of optimising the mental wellbeing of every lady from conception right the pregnancy, and then, with her chosen partner, right through the formative years of that child, and then

hopefully supplemented by an educational system that continues to maximise wellbeing through to maturity.

I think so many of the problems, and you can start off with household domestic (indistinct) and you could go right through substance abuse/crime, attitude in workplace, attitude to study. It doesn't matter, there is not one area in life that optimum wellbeing doesn't have an accepted parting. And so, I think the - and the - you would understand the economics of that, because when someone's not functioning at their best, they are more likely to have time off work. They're more likely to be slower to get back to work. When they're working, they're not as innovative, not communicating as well. I think if you look at the economics of all that.

I mean, we could select just one of those things I alluded to, and that is just substance abuse. I mean, I'm not sure you've looked at the economics of people, you know, with vehicle accidents, and so what the impact is, and if we could influence that, if we could reduce the number of people that feel the need to use substances, how much better our system would be.

PROF KING: Can I then (indistinct) your general comments, but we've also made some recommendations, draft recommendations in the area, which I'd like to get your view on. What appears to be one of the most controversial recommendations that we made goes to a social and emotional wellbeing check for children, put as part of their - I think it's their three-year-old or their four-year-old health check, which was directly meant to address many of the issues that you've raise, exposing where a child is having developmental issues, providing support for the family, and if a child is having developmental issues at that stage, the evidence is there, but it will usually reflect a broader family issue.

Now, we've had massive pushback on that, starting from the day our report was released with, you know, what was it? Psych testing for tots - - -

MS ABRAMSON: For tots, yes.

PROF KING: - - - was the headline in one of the major urban newspapers, and it seems to be that people interpret that sort of recommendation as meaning children will be drugged. How do we move the conversation - how do we - any suggestions for how we need to reframe this debate, because that's not what we mean.

DR RIESSEN: Absolutely. I think that it's got to start from the top. I think all these things, there has to be not only the Productivity Commission and the National Mental Health Commission, but it's got to be top of government, top of business, top of education, everywhere. Everyone has to have ownership, and mental health literacy, of course, as we know, you would have seen great variation in it, and so I think, first of all, we - that would be my first step on a plan is to improve mental health literacy right throughout this country, and make sure everyone knows what good mental wellbeing is, and how you achieve it.

And you achieve it through natural - you know, providing support, providing stimulus, providing (indistinct) providing - you know, to children, all the way through. And so that's why the chosen partner of the pregnant lady has to be on board with that as well, and I know that's going to take a generation or two to really nail, but the - I do think you would start, I would start with every service and I would sort of use local government services, I think, as the facilitator of pushing that plan, and yes, but I think that's really important.

And, of course, it should start, as I said, with conception. So you should be able to get it into every pregnant lady and they should all know the importance of maximising not only their own mental wellbeing, and then part of it is all children should then see examples of - and if we could - that's why you need government support. Children at the moment see how our governments behave, how do they learn respect? How do they learn responsibility? You know, I think we need to - you know, everyone needs to take ownership of this whole thing.

I mean, we saw the effect of group resilience during the bushfires, and we see it during wars. If we could in some way initiate - you know, and that's why governments are important. If we could somehow initiate a group responsibility, an Australian responsibility to mental wellbeing, then I think we'd be well on the way to decreasing the numbers of people with mental illness, but also improving the wellbeing of others that are below the surface of the water.

PROF KING: Yes. So that it sort of - so Aboriginal and Torres Strait Islanders use a term, and it's used clinically as well, of intergenerational trauma. Is it an issue that we've got to get an educational - get the Australian education through the Australian public. The family's at risk, then kids are at risk.

DR RIESSEN: That's right.

PROF KING: And it's not just physical, it's mental.

DR RIESSEN: Indigenous people are a very important group, and glad you're onto it, because, I mean, to me it's the gap. The gap between the elders, which seems to have switched into more the female, usually, in the indigenous people. The gap between them and their young people who are being thrown into our western world, and it's very hard, and we need to keep those young indigenous people closer to their roots and their families, but at the same time, integrate them into all the benefits of the western world, but not letting them lose their important roots.

I'd just like to just quickly say, you know, I had listened to all those transcripts, and I will now - getting back to observing the last 56 years. The influence of the pharmacological industry is driven heavily by psychiatric influence, and enormous money has been put into suicide strategy, and we haven't seen, significantly, the improvements. And I really want to give a plug, before I stop doing my advocating, to - you guys are really maximising your listening to those with lived experience.

Unfortunately, the whole medical system is orientated to people who are big pharmacy, you know, chief psychiatrists, services where, you know, they've got a set program that a lot of other people in them are doing good jobs, but they are not really influencing the development of mental health improvement, or you know, or preventing mental illness, and I think we could listen more to carers who are, in essence, the backbone. If we don't have carers, you look at the economics of carers, it'd be enormous, and so I think you've got to get into really listening to the advice and experience of people with lived experience and to carers, and I think that would be really a significant way forward, and I would like to see that in the plan.

The barriers to change, I think, are that, you know, the current medical pharmacological system, as you would know. But I think, you know, all the evidence from the National Mental Health Commission, community scenes, to your own transcript, to the World Health Organisation publication, all show that we should be increasing the human rights, and we should be listening to consumers and should be gathering that knowledge. The other big thing is the intrusiveness and - of the media and social media.

That is having a fundamental part, big part. People don't get time to adapt. They don't get the time to develop healthy cognisance and behaviour, defence mechanisms, to allow them to cope with all this news. And then, if they see it, you know, on the main screen how our politicians behave, the way other dignitaries behave, you know, I think this can't be underestimated as to why our young people are, on the whole, rebellious, restless, and have less respect. So that's just one thing.

Another thing is, I think, that should be used is we can use that media positively. You know, we can use - get positive messages out, and I would think that was a worthwhile economic thing, is to - for the Productivity Commission to look at social media and get positive messages out. Secondly, there are Acts, good Acts on checking how people's wellbeing is, and they should be used where everyone suspects people are not doing well, and I think that would improve the feedback and that - and just talking on that, in case I'm not through on time, time's going, there's that - with suicide, particularly, it's all - and I think, RU OK - RU OK is a good thing, but if you ask the question, RU OK, then surely you've got a responsibility to follow it up.

MS ABRAMSON: Yes. It's the next step with RU OK. Yes.

DR RIESSEN: And it has to - and so that (indistinct).

PROF KING: Yes.

DR RIESSEN: Now the other barrier, I just quickly want to say, in view of the previous speaker, is when I was consulting in general practice and the availability and use of psychotherapists came up. We all recognise the benefits of psychotherapy. It's fantastic. But how long's a piece of string? I mean, they were first offered one to six appointments. Everyone used six. And then they would apply for another six, and they would use those

six. And not only that, on a whole, there was poor feedback to the GPs. No good protocols for management, and so I think the - I am just concerned.

All I am is expressing a concern, having recognised the benefit of psychotherapy. Everyone could do with checking, to a mentor, to somebody - is the - what this is going to do economically, and I - there's got to be controls and there's got to be good feedback and protocols that accompany it, and so I would just like to make you aware, particularly if you're going to now think of the NDIS along similar lines, then I think there will be a blowout. There'll be an economic blowout with psychotherapy, and I know it's important, and that's what I did in general practice myself.

I'm all for, you know, improving outcomes, but it's - I just see it as a dilemma that you have to confront.

PROF KING: Yes. So we've got some draft recommendations around the MBS funded services, because there is no evaluation of the consumers in general. There's certainly no requirement on the psychologists or the person finding the therapy to ask the consumers and get feedback, and there's - the feedback to GPs is pretty perfunctory.

DR RIESSEN: I think there's got to be individual responsibility by the consumer. I think there's got to be a responsibility by the GP. There's got to be responsibility by the psychotherapist, and the - no government has a bottomless pit of money.

MS ABRAMSON: No.

PROF KING: Can I just ask you, because I want to ask one question, but we will have to wind it up. You're a retired GP. You've mentioned the issue on - with the counsellors and so on. One of the things that's been brought to our attention is things like - and you mentioned the incentives and the drug companies. So, for example, GPs and the prescribing of antidepressants has been raised to us as a significant issue. But it's been put to us that, well, consumers go into the GP if they're not feeling well. Do you expect a script? Do you expect a medicine at the end of it? That's what Australians expect out of a GP, so they're just responding to what the consumer wants. How do we change that cycle? How do we break that cycle?

DR RIESSEN: Okay. Well, that's got to start with medical training, medical courses, and I think you should - I would be advocating down the track looking at a specific mental health GP specific course, or such. I think the (indistinct) with mental health, I don't think it goes well with money. I think people almost should be on a set wage. You know, and I think that, you know, the time scenario. You know, you've got to have - be flexible, and you've got to have plenty of time. It's no good if someone's really got something on their mind, but it took a little while to be confident with you, or whatever, it's - let them release it, but you've got to be alert to it.

And if you're really booked out the next two days, you know, it's very hard. I mean, I think the whole - that whole thing needs to be addressed, and I think in my 31 pages to -

sorry about that, but the - - -

MS ABRAMSON: No, that's fine; 31 is fine.

DR RIESSEN: Good. I did address that sort of issue. But finally, my big other final dilemma is plans. When I heard of the 2030 plan, I went, oh god, I could be dead. And I know, if you look at the history of plans and governments, plans get, you know, set aside, recycled, reviewed, and I - you know, and the one thing I'd like to add, you've got to have achievable plans, and I would like think, and I just tongue in cheek, I wrote down, for instance, if by the end of 2020, all members of parliament had a full knowledge of what mental illness and what the influence of mental wellbeing is.

Further, there should be good bipartisan agreement in trying to ensure to optimal parliamentary behaviour and transference on all fronts. Because I am concerned of just what that (indistinct) does. By the end of 2020, all Australians should know not to stop when just asking RU OK, but to absorb the responsibility to follow through to full mental wellbeing. By the end of 21, Australians will know the importance of - all Australians will know the importance of maintaining good mental health and wellbeing, and accept greater personal responsibility for this.

And by the end of 21, significant progress will be made from the Productivity Commission and the National Mental Health Commission with those with lived experience. By the end of 22, all women will be supported from conception to optimise their mental wellbeing, by good local government initiatives, and engaging their chosen partner to fully support. By the end of 22, also all child medical and health encounters will include assessments of wellbeing.

And by the end of 23, all stages in the education process will strongly advocate mental wellbeing at all times, teaching the dangers of substance abuse to the immature brain. Teaching will increase respect, increase personal responsibility, and increase resilience. I just gave an example of achievable plans.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you.

PROF KING: Next, we have Paul Creedon. Good morning, Mr Creedon. If you're able to just state your name, any organisation your represent, and any opening comments.

MR CREEDON: Sure. My name is Paul Creedon from Skylight Mental Health. I will talk, if I can, a little bit about what Skylight Mental Health is, and then talk about some of the key issues from our perspective. I will also leave copies of my - over here so that you can go through that later, if you wish. Just to give a bit of a background about Skylight Mental Health. Skylight Mental Health is an organisation which was created by carers in 1983 as the Schizophrenia Fellowship of South Australia; 2002 it became the Mental Illness Fellowship of South Australia; 2006 it merged with the Mood Disorders

Association in South Australia, and late last year we changed our name formally to Skylight Mental Health.

We're essentially a provider of a range of psychosocial and community-based services for people with primarily a diagnosed mental illness. Not every one of our participants has a diagnosed mental illness, but all would be in the more severe assisted end of experience in terms of mental health. We currently operate across metro and country South Australia, with nine sites across the state, and we believe very strongly that mental illness shouldn't define someone. We value youth experience of peer led programs, and we use those to enhance recovery, personal recovery in particular, wellbeing and strength and resilience.

We value understanding connection, optimism, and courage in our work, and our interactions with service participants and community generally reflect those sorts of values. Our vision is a broad one. It's a vision for South Australian community which understands mental illness and responds with confidence, respect, and hope, and our mission is to increase opportunities to achieve good mental health, to promote acceptance of mental illness in the community, and provide quality services to people with mental illness, their family, and friends.

Last year, we supported well over 2,000 people in a variety of services and programs, including one-on-one support, group skills development and activity programs, counselling, NDIS information sessions, NDIS services, support coordination and support facilitation, short holiday breaks, carers' supports, and carers' information services. All of those services are provided free of charge to consumers, primarily with various state and federal income, as well as NDIS contracts.

Importantly, given the last speakers' comments on lived experience, annually at Skylight we do a survey of staff satisfaction as well as consumer satisfaction in the organisation, and our most recent staff satisfaction survey, which was in October of last year, showed 78 per cent of our staff reporting a lived experience of mental illness, or of being carers of someone with a serious mental illness. Skylight Mental Health is also an active member of MIFA, the Mental Illness Fellowship of Australia; South Australian member, and many of the points that I'll talk about here are reflected in the detailed MIFA submission to the Productivity Commission's draft report. So I've got a copy of that that I'll give to you as well.

Let's just reflect, if we can, for a moment on the numbers, and these are numbers from the Commission, so you know them well. Almost four million people of all ages experience mental illness each year. Around 690,000 of that group will have severe and ongoing mental health issues. Around 290,000 of that group will require some level of psychosocial community support and rehabilitation each year, and it's likely that most members of that group of 690,000 will require some level of support at some point in their life. Even though many of them will get through with minimal levels of support, some will require significant support.

In the draft report, the number of people with complex care needs is noted as totalling 350,000 people, of which 190 to 250,000 people have episodic or persistent, severe mental illness and have significant complex needs arising from that illness. Despite this, modelling from the NDIS estimates that 64,000 people will be eligible for the NDIS. That's between 25 and 33 per cent of the group that are identified as needing something. We know that the NDIS, at this stage, is only tracking at about half that number. So perhaps as few as 12 per cent of people in South Australia who've - in Australia who require that level of service are getting it through the NDIS.

We do know that there is lots of variation between states and territories and Commonwealth funding, but we do know that the federal government is funding continuative support and national psychosocial support measure, which support perhaps another 13,000 people across Australia, and there are perhaps another 20,000 people across Australia who are receiving supports via some - or one or other of the state or territory funded psychosocial programs. So we know that perhaps 26 to 34 per cent of people with significant complex needs are receiving the psychosocial supports that they require, and so there are two or three times that number who are just not getting access.

MS ABRAMSON: Sorry, was that 24 to 36 per cent?

MR CREEDON: Per cent.

MS ABRAMSON: Yes.

MR CREEDON: 34 per cent, sorry. I can't read my own writing. (Indistinct).

MS ABRAMSON: So those are the people that are getting support?

MR CREEDON: That's right.

MS ABRAMSON: Yes.

MR CREEDON: And are potentially getting.

MS ABRAMSON: Yes.

MR CREEDON: We have a, and you would know, very fluid system in terms of - and I'll talk about this in a minute - the definition of what psychosocial support is, and the value of it, is applied differently not just in different states, but in different towns and in different regions, and it's one of the things that I'll talk about in a moment.

MS ABRAMSON: And we'll have some questions for you on that, thanks.

MR CREEDON: Please, please. So, let me look firstly at what psychosocial services are. It's, I guess, our view that psychosocial services didn't receive enough attention in the draft report, given what we believe that it can achieve. It was mentioned certainly,

but it was mentioned as an adjunct clinical service, rather than - - -

MS ABRAMSON: That's a good point, and can I just - I know I'm interrupting you, but we understand that and we've got some questions about can we actually do that a bit better.

MR CREEDON: Okay. That would be great.

MS ABRAMSON: We understand.

MR CREEDON: If you like then, I'll sort of just - - -

MS ABRAMSON: That would be really helpful.

MR CREEDON: - - - (indistinct) rather than going through as much detail as I had intended. I guess we need to understand that psychosocial support has a significant impact on people's lives at a personal level, at an interpersonal level, so their relationship with other people, but at a community level as well, because it helps reconnect people not just with themselves, but with the people that surround them, and the general community. It has a significant impact in that regard. It strongly links to a concept of recovery, the concept of personal recovery, or as the previous speaker, he mentioned the words human rights, and I think that's where a lot of the mental health sector is now starting to talk about human rights rather than recovery services. The focus being on if you are a human being you have rights to free speech, you have a right to communication, you have a right to proper care, you have a right to proper services that are going to help you achieve the things that you would like to achieve in life, the same as any other people.

That kind of overrules, if you like, trumps the idea of recovery, because it assumes recovery is a part of your human rights, something that you're entitled to.

Consumers frequently report that recovery services are more critical to them in terms of their recovery than clinical services, and there are lots of examples. In South Australia, as I'm sure in other states, of SA Health reviewed services, the Individual Psychosocial Rehabilitation Support Service, the Individual Home Based Support Service and the GP Access Programs, which have all demonstrated that those psychosocial programs prevent people from becoming unwell and then needing to access more extreme clinical services or hospital emergency departments. So the savings there are quite clear, I think.

The difficulty I think for health services is just because there's less demand from beds doesn't mean you can take the beds out of the system.

MS ABRAMSON: We're right across that.

MR CREEDON: I'm sure you are. This leads us I guess to the concept of the stepping up and stepping down model, and it's a model that in the main the mental health sector is familiar with, but if we use that analogy – it's not a complete model, but if we use that

analogy of stepping up and stepping down, we imagine a staircase, and it's got a similar sort of visual to it, and in that visual, psychosocial services are the handrail that help people step up and step down. They're the thing that keeps everything stable and allows people to pass that point.

MS ABRAMSON: I like that very much.

MR CREEDON: To just hang on to while they're working stuff out. So it doesn't matter whether they're stepping up or stepping down or just staying where they are at the moment, because where I am is just okay, that handrail is a thing that keeps them safe at that point in time. I guess that's the value for me at a gut level of what psychosocial services do, and that's the stuff that the consumers at Skylight, and in my previous roles, have talked about on a fairly consistent basis, "That's the thing that kept me safe".

MS ABRAMSON: Mr Creedon, one of our difficulties, if you don't mind me taking - - -

MR CREEDON: Go ahead.

MS ABRAMSON: One of our difficulties has been when we represented the stepped care model, in a graph sense it gave too much of an emphasis to the clinical. It's not what we intended to do, and we're, to be honest, struggling to work out what it would look like and we've had various things presented to us, that showed that actually we get that, we get that psychosocial really matters, but the diagrammatic representation for us has been difficult, so any thoughts on that would be welcome.

The other thing aligned with that is that one of the ways that psychosocial supports are made available by government of course is when there's diagnosis. So we're also struggling, to be honest, with well, how can you make the supports available without having some reference point, because that's just how governments deliver programs. So I know I've interrupted you, but that would be really helpful.

MR CREEDON: No, no, it gives good direction, because I'd like to say they don't always do that. If we look at that, and using South Australia as an example, the state-funded mental health services is an incredibly direct link between clinical services and psychosocial services. The vast majority of psychosocial services you can't access unless you are receiving a clinical service.

MS ABRAMSON: Yes.

MR CREEDON: The contrast to that is the Federal Government's previous program the Personal Helpers and Mentors Service, which, now de-funded, did not require a diagnosis. The NDIS does not require a diagnosis – sorry, the NDIS struggles with that intellectually, but the paperwork for the NDIS does not require a diagnosis, it requires a pattern, a history, a way of demonstrating there has been a significant issue.

That's the model that I think works best. Because what it allows people to do is come back into a psychosocial program as and when they need a service, rather than having to go through a clinical gatekeeping program.

Again in South Australia, for a number of years there's been lots and lots of debate around how we could break down the barriers between that nexus, break down that nexus between clinical and psychosocial. And there has been a general comfort amongst clinicians about breaking that down.

The discomfort is not the clinicians, it's the funders. So the funders struggle with how do we measure outcomes – they struggle with that now, but they struggle even more when you take away the diagnosis part of it. Because the question is often asked – and so I use the examples of the GP Access and the Individual Psychosocial Rehabilitation Service – the GP Access Program is a program specific to one of your speakers later on today, UnitingSA, that one you don't need a diagnosis, the individual psychosocial you do need a diagnosis. They produce exactly the same result, they have exactly the same target groups, so there is no logical reason for it.

It is really one of what governments have been trying to do to ration services, knowing there's this massive demand, yet this very small bucket of money.

I guess it makes it easier to give it away if you can actually use an example like you don't actually have a diagnosis. We know, despite that, that diagnosis in terms of mental illness is not very stable.

MS ABRAMSON: It changes. We've had a lot of evidence from people.

MR CREEDON: Yes. And there are lots and lots of people that providers in the area have come across who very clearly exhibit mental illness behaviours but have never been diagnosed, they've managed to stay out of the system for many years, they've been guarded or protected by family, they've lived on the streets et cetera. And to assume that that group don't have function within this is a ludicrous concept.

PROF KING: Can I just follow up on what you said there, because whilst it would be great if governments integration services, we know they will, because they have budgets, and it's an issue – if you don't have a diagnosis doorway for psychosocial supports, and I take completely on board that it's not a very good doorway – a great piece I was reading on the weekend – which I can't remember if it was a paper from one of the journals or one of the submissions, so apologies if someone in this room wrote it – but a comment just providing the evidence that actually if you don't do a diagnosis as the first step, but in fact you treat what's going on and worry about diagnosis down the track, actually the outcomes appear to be better, rather than you try and box people up front, which is interesting from a clinical perspective.

But if you don't use a diagnosis at the doorway, how do – the government will want to ration – okay, so I'll give an example. So say if somebody, this is a real example that was

put to us – somebody who’s got a hoarding disorder, they’re functioning perfectly well in the community, they’re holding down a job, but they’re about to lose their house because of their hoarding disorder, they’ve failed a number of rental inspections, how does that person get the housing support they need? They don’t need clinical support, they need housing support. But how then do they get on the radar, what’s the doorway, what’s the gateway, and how do we convince the government that they’re not going to have everybody running through the gateway?

MR CREEDON: It’s a very good question. Part of the issue is that we’ve created a system where you have to be in crisis before you can get any support. So we’ve actually shuttered off an entire community, saying you don’t need support, you don’t need anything because you’re not committing suicide or attempting to commit suicide at this moment in time.

What you’re talking about is there should be multiple entry points depending on your particular needs. So we have in some ways that, if you go to your GP you get access to a counselling service if that’s the appropriate service. That’s one entry point into the system, but there is nothing between there and a suicide attempt.

PROF KING: Indeed.

MR CREEDON: So there needs to be multiple entry points and people being able to move in and out of systems as and when they need it. We have a system approach which says that you are unwell, we have to medicate you and make you better, and then you leave the system. It’s actually not acknowledging that many of the issues are actually community social issues and where we’ve traditionally had services in Australia which would be called community services, as opposed to mental health services, which actually assist people to manage in the community and to develop and maintain safe households to actually interact with children and other children in the area affected.

All of those sorts of things were built into our service structure in the past and they have all been taken out of our service structure, so that the only way to get support is for this particular person to be identified as having a mental illness.

MS ABRAMSON: Could you expand a bit on that for me? I’m really interested in – you said “That used to be there”, what did it look like?

MR CREEDON: Community services, there were lots of community centres, there were lots of drop in centres for people in the community. They’ve largely been de-funded over the last 20 or so years. We used to have lots of community organisations and non-government organisations who did parenting classes, who did support groups, who did interactive, who did reach out into the community. They’ve all been de-funded over the last 20 or so years – all is an extreme statement – many of them have been diminished at least over the last many years.

So we’ve shuffled everything that would be seen as a community issue into this area of mental health and we have – and part of what I’ll talk about if we get a chance in a minute

is about the way we misuse the language about mental illness, mental health and wellbeing to mean the same thing, when they're quite distinct categories.

MS ABRAMSON: I'm interested in hearing about that, and also when you're talking about that, a lot of people have spoken to us about the recovery model. So in that language, we'd be interested in your views.

MR CREEDON: It's a curly one, and if I can take off my mental health hat and put on my disability hat, from a previous life, where I worked in disability for many years and was very active in the community consumer movement. The term "disability" is one that is generally accepted by people in the disability community. They accept it because they chose it. In the area of mental health, people with mental illness didn't get to choose any of this, this has all been applied by other government organisations or funders to make it fit their definition.

So my experience is that most people who have a mental illness are comfortable with the word "mental illness", they get confused about having mental health, because we rarely talk about mental health when we actually mean mental health. We usually talk about mental health when we talk about being sick. It's kind of like we don't talk about heart health when we mean heart disease; we talk about heart disease. So we separate those things out.

So I don't think there's ever been anything that's ever asked people that have experienced what phrase would you prefer, but my experience is that most of the consumers that come to Skylight, or in my previous life came to our services at UnitingSA, would have talked about them having mental illness.

MS ABRAMSON: Yes, we did get some commentary around our use of the terms "mental ill health", and to be honest, Mr Creedon, we ourselves were trying to find the right language to use.

MR CREEDON: Interestingly, I think that since the words "psychosocial disability" have become a bit more popular around the NDIS, agencies are leaping to that particular phrase. But I think that's as much about it gives legitimacy to the target group as much as anything else, because it was used or brought in – it's been used by the World Health Organisation for some years, but its first appearance in Australia was around the NDIS, it's now become the term used for anyone who might well have a mental illness, so it's become this catchall phrase.

Perhaps that's because we've never asked consumers what they think the right word is, and pretty much every word is ugly, it has a whole lot of connotations around negativity rather than positivity.

MS ABRAMSON: Yes, certainly people have spoken to us about the recovery model.

MR CREEDON: Yes, and the recovery model, and again we need to separate out the personal recovery from clinical recovery.

MS ABRAMSON: Yes.

MR CREEDON: So clinical recovery is did you get the right drugs, whereas the personal recovery is are you doing okay as a person.

MS ABRAMSON: Yes, can you function in your community.

MR CREEDON: Yes, and are you doing the things that you want to do and achieve. And we would argue that term, terminology, is now being corrupted as well, and that's because it's being used in a clinical framework to define you've got the right medication, rather than as a human being you're doing okay. So that's what we're arguing from a consumer perspective at the moment, that the human rights perspective is a more appropriate way of looking at it.

In my own organisation, Skylight, what we do is we don't talk so much about mental illness, we talk about people and we talk about people who come in. The only ones we actually define are staff. So they have a name, they're staff, but everyone else is people, and we try and break down some of the barriers just using simple language like that.

PROF KING: Just wary of the time, so any final?

MR CREEDON: Look, the rest of it is in here, many of the other things are covered in the MIFA submission, so I won't go so much into those. I do talk about the words like recovery, personal recovery et cetera, and there are a number of recommendations on the back page, but there are also the recommendations that were made by the MIFA submission, so I won't need to go into that.

PROF KING: Fantastic.

MS ABRAMSON: Mr Creedon, we might – if you could leave your details, I think the staff have them, I would like to follow you up on some of this conversation about language and thank you very much.

MR CREEDON: No problem at all.

PROF KING: Thank you very much. Next we have Dr Benjamin. Welcome, Dr Benjamin. If you could state your name, the organisation you represent, for the transcript, and any opening comments. I do note that we do have both your pre-draft and post-draft submissions.

DR BENJAMIN: I do appear to be one (indistinct). My name's Tom Benjamin, thank you for inviting us to this consultation and for paying our respects. I'm a registered psychologist in a medical school lecturer, but today I'm representing the Medical

Consumers Association, founded in 1976 by my University of New South Wales colleague, Dr Erica Bates, who warned way back then, everyone in the community becomes a potential patient in need of preventative psychiatric intervention.

MCA wrote the original patient bill of rights and I personally had been given power similar to a Royal Commissioner under the New South Wales Public Hospitals Act to report to the Mental Health Royal Commission on the topic of deaths and coverups.

Now, our detailed references were submitted, and I'll also submit this transcript, made by PC, and I'd like to give you a handout that you can follow, so I can abbreviate it a bit in this verbal commentary.

MS ABRAMSON: Thank you very much.

PROF KING: Now, again, just for the transcript, we've received two pages of handout.

DR BENJAMIN: Now, these are a summary of consumer protection considerations, I'll just highlight them very quickly. A draft report presenting one fait accompli option is not acceptable. The most important policy option is the no regulation option. Regulation is a last resort. The Australian Competition and Consumer Commission (ACCC) is our principal legislative weapon. Registration of these professions should be removed unless there is overwhelming evidence for retention.

Cartels are immoral and illegal, because they not only cheat consumers, they're destroying other businesses by controlling services to the point where honest and well run companies cannot survive, destroying consumer confidence in an entire sector.

These words should all sound familiar, they're not MCA's words. I just read out to you current government policy that's "intended to be read by every member of the Australian Public Service from the most junior member of the policy team to the departmental secretary", the same ministry that wrote your Terms of Reference.

Now, the proposals in your draft report have resurfaced time and again; 2005, 2011, the results have already been catastrophic. The draft proposal, with all due respect, has potential to make things worse and wreck the economy. Again, these are quotes from others, not MCA. You have many warnings among your hundreds of submissions and your own earlier reports.

For example, in concern that the media had perhaps misinterpreted the idea about the assessment of zero to three year olds, well, the most dire warnings about that sort of thing came from this gentleman, Dr Allen J Francis, who wrote this book, the Diagnostic and Statistical Manual, which we're all familiar with.

He came out of retirement specifically to warn the dangers of diagnostic conflation, over-hype treatment, and drugging very young people. Just this week in my university role I passed around several articles where they were trying Prozac, not on two year olds, but on

one year olds. So it's not a media fantasy, these are warnings from authoritative sources. For example the APS, in your workforce hearings back in 2005, warned that the telepsychiatry movement would just result in a route to drugging.

So again, it's not the media beating these things up, these are warnings – the most dire warnings about bounty hunters in the schools came from the United States Congress, and the quote about wrecking the economy was from Dr Allen J Francis, because the idea that with the stroke of a pen you could create 10 billion patients overnight, has changed one line in this book.

The ACCC calls the health sector a new priority area, but the commissioners have warned that the governments have been reluctant to take strong action, and Commissioner Graeme Samuel said the health minister even told him to back off. So the current minister for health wrote to us at MCA stating he didn't want to burden the ACCC while your inquiry was underway. So it's back off, the ball is in your court.

As a consumer group, our punchline, as in our written submission, is an ACCC inquiry. The evidence now available to the Productivity Commission does not in any way support the \$500 million a day of saving, the proposals are much more likely to wreck the economy.

False psychiatric labels or hundreds of thousands, if not millions, of Australians can create a pill popping, intergenerational underclass of people identifying themselves as having a mental disorder, a get out of work free card. I already see such people in the clinics. Evidence we've submitted points toward suicide rates made worse, higher costs for placebo level treatments, waiting lists, excessive psychiatric labelling, removal of stigma, making the false positive seem acceptable, prescription drug problems, mass unemployability, unsustainable mental health workforce, with no savings from prevented illnesses.

Our solution to all this, the ACCC. Although you have section 52 barring false and misleading evidence, as Lord (indistinct) would have said, "An opinion so arrived differs by the whole winds from the heavens from the decision of a court".

The structure of the mental health sector workforce should be subjected to a full ACCC inquiry. The 2011 Senate inquiry heard identical proposals and concerns; the opposition criticised the inquiry process. Well, they're now the government. The debate was heated, with over a thousand submissions back then.

As for the essence of consumer protection, what it's about. Well, let's just say that we have here expensive water, contaminated water and tap water. Consumers are concerned that if the expensive water turns out to be tap water or has some contaminant that makes it worse than the dodgy water.

Mental health sector is exactly the same; you have here your cults and your illegal drugs. Here you have your expensive, regulated prescription drugs, lobotomies, psychotherapies of all kinds, electroconvulsive treatments and electromagnetic treatments, and here you have your free consults. What if you find that these people get no better results than these?

Who should pay 300 bucks for a glass of tap water? That's a typical consumer question. We need to clarify it.

The evidence doesn't show that mental health treatments don't work, the problem is the opposite. Everything works, including the placebo or doing nothing. There are hundreds of new psychotherapies each year, maybe they work, but so does generic counselling done by unregistered, uncertified, minimally trained unpaid persons. So why pay 300 bucks a glass for tap water or a sugar pill?

The statistic common in journal articles will hail the treatment as being successful if it has an NNT as low as four. Now, NNT is the number needed to treat, refers to the number of people who would need to be exposed to the treatment for one to benefit. Let's imagine this in dentistry.

Clint Eastwood, the dentist – “I know what you're thinking, I've already drilled three people this morning, one of you will get better. I've got to ask you, are you feeling lucky”
- - -

MS ABRAMSON: You do a very good impersonation of Clint Eastwood, I must say.

DR BENJAMIN: And the NNTs in the drug trials are commonly higher than four, sometimes as high as 9 FFD, so as a consumer group, what we're asking is who speaks for the other eight persons. With this idea that one out of two people has a mental health history, submissions to your Commission said that the real figure might be more like the traditional three per cent who have a serious mental illness condition.

Of course, the kind of people who are going to come to an inquiry hearing will be those who care for or are concerned with the three per cent. Our question, as Medical Consumers Groups, who's speaking for the other 97 per cent? And if I'm in my clinic this afternoon seeing somebody who walks in and I think, “Well, actually they're in the 97 per cent, I don't want to run a mental health treatment plan on them because it gives them a label”. To save a few bucks, people will take these labels.

With childhood detection it becomes even scarier, because the Commission has been told it's difficult to predict specific psychiatric conditions in the teenager. Sure, you can look at a family and say, oh, there's likely to be some problem here. Sure, any of us can do that. Try to predict which psychiatric condition that they'll have at age 30, we know that you can't even do it at age 18, and now we're saying we can do it as soon as they're born.

The agenesia a decade from now will walk in here and testify we used to be assigning the label before they're born, but they'll have no say in it. The other kids in the schoolyard will, because when they find out that they have this mental health illness label, this risk label, in reducing the stigma only makes it credible. I know the label sticks because I've had to, as an expert witness, defend people in court who – not defend them, but people who have a motor vehicle accident and they'll try to come up with a reason to give them a psychiatric label. Could be something they did in school, like they missed a day of school

or something like that. The label sticks, yet it also appears to their unborn children because it becomes family history of mental illness.

I've even seen it where patient said – I said, “Well, why do you have this mental illness thing in your record”, and they said, “I think a cousin had ADHD. I think a cousin had ADHD”. That passed through three reports and ended up being “History of mental illness”, to squash the insurance claim. It goes on every day.

Now, the two tier stepped care system is basically a caste system. It sounds logical that you should have advanced skills to treat extreme conditions, but that's general medicine. It's never been shown to apply in the mental health sector. The submissions show there's no evidence for difference in outcomes in any mental health conditions attributable to training, and the training is costly, up to \$30,000 a year for reports. It's always been a closed shop.

Back in 1963 we read that there were 50 applicants for eight places, and the evidence now is that it has not and never will improve, they'll never have enough places to train all these people, and there's no reason to. The evidence for decades has shown that psychotherapies don't beat each other, or placebo. The main damage of the stepped care category is confusion. When a referral walks through my door I've got no way of predicting that they might be classed as moderate to severe. So what if I think they're one of the 97 per cent who don't have a serious mental illness. It might fear I'll get in trouble with AHPRA for refusing to treat or I'm supposedly exceeding our skill level.

And the poor GP is in a similar position, they get paid more to write a mental health treatment plan than I do to carry out the treatment, but they risk an audit if they refer it to the general allied health practitioner or a counsellor. So their safe default is to give them a psychiatric label for life, refer them to the clinical psychologist and psychiatrist, irrespective of waiting lists, high price, psychiatric labels, placebo level and drug prescription.

Does anyone seriously think I'd sit in a clinic unpaid to act as a referral agent passing people on to the waiting lists of my colleagues? No, I will close shop. That's not a prediction, that's my own experience. I was offering bulk-billed services in a regional and rural area, we were also an indigenous clinic, I closed the two practices to move here to Coffs Harbour to take up a position.

The town I left behind is now surrounded by bushfires, I can't help them. The town is ineligible for general psych teleservice. Before leaving I recruited volunteers who were highly qualified, one with a PhD, who would have been quite happy to replace me in the role, they've been working for free and they would have charged little more than the gap fees.

Thanks to the AHPRA requirements, they remain unregistered. Some are in fact unemployed, and they've left the mental health sector. So I doubt that I will be replaceable.

So government money, for who? I'm told that the ECT machine is running hot and there's a queue for it. That's your mental health service.

Our clinic here in Adelaide is the same. We have a highly trained psychotherapist counsellor, she's not had a single referral. I get referrals because I'm registered with Medicare. I rang Medicare and they advised me it would be illegal for me to pass that other 97 per cent patient on to the counsellor. So this afternoon I've got patients on the book to see, she has none. Unsustainable.

And you were warned back in 2011 – sorry, the Senate was warned – that many patients have little choice but to use the funded, hence cheaper, less well trained practitioner. That was a warning from the APS. And your own 2005 workforce report said the skills of many health workers are not being utilised to full advantage because of systemic impediments.

So just pushing on because of time - - -

PROF KING: Yes, we're aware of the time, and I do want to ask you some questions.

DR BENJAMIN: No, that's fine. Our recommendation is that this entire mental health workforce edifice should have presented its case for existence to the ACCC. The ACCC Commissioners have called for it, it's the law, it's long overdue. And the Minister of the Commissioner of you has warned, there are a relatively small number of situations that justify direct government intervention.

PROF KING: Thank you very much. On the ACCC one - - -

MS ABRAMSON: The former Commissioner.

PROF KING: I used to be an ACCC Commissioner.

DR BENJAMIN: Okay, all right.

PROF KING: That unfortunately, they don't have jurisdiction over the colleges, which is something we found out when we were trying to move some things. You suggested - - -

DR BENJAMIN: The Royal College of Surgeons actually had to make an application to the ACCC, they did.

PROF KING: The formerly – there's various practices that have to be authorised by the Commission, I'm not sure if the General College of Surgeons, but the actual restrictive practices that – I shouldn't be judgmental – the practices of the colleges in terms of registration, my understanding is they're actually outside the Act. But that doesn't mean the government couldn't refer to them.

DR BENJAMIN: My understanding is that they could, and they actually submitted, and I'm saying that these other bodies should do so, because I think they'll be empty handed if

the onus of proof – see, the difference is, with all due respect, I’m not going to be cross-examined, you’re only going to ask me some questions. But - - -

MS ABRAMSON: We can if you’d like us to.

DR BENJAMIN: No, no - - -

MS ABRAMSON: I am a trained lawyer.

DR BENJAMIN: Well, I might consult over here, you can’t cross-examine them.

MS ABRAMSON: I understand.

DR BENJAMIN: And the thing is, I can’t cross-examine people who might have made up lies about me, as happened in the Royal Commission in New South Wales. The Department of Health complained about the report into the psychosurgery, I had no way of knowing what they said, couldn’t defend myself, and what about the dead patients?

PROF KING: Sorry, I took us off track, which I shouldn’t do, but I have a tendency to. Take on board everything you’re saying about the early childhood wellbeing change. This faces us with a dilemma, or I see it as a dilemma, I want to understand from you if you see it as a dilemma or something that we just don’t need to go near. So my understanding of the evidence is that there is significant evidence of early childhood trauma, issues of attachment, families that are struggling, will affect the children and will affect the development of those children, will affect their success in later life.

DR BENJAMIN: Well, I think that - - -

PROF KING: Is that wrong?

DR BENJAMIN: Would you like an analogy?

PROF KING: Yes, please.

DR BENJAMIN: If you take Serena Williams and trace her back, you could probably say that at age 2 she was showing signs that she could become a good athlete. That doesn’t tell you it’s going to be tennis.

PROF KING: No, no, that’s right.

DR BENJAMIN: She could have become a pianist. And what I’m saying is that I have no doubt, and psychologists say this all the time, one can easily – and so can I, I can just look at somebody and smell them and tell them this family has got some big problems. Well, no issue there. The issue is you can’t predict something that’s going to happen when they’re 30 years old and the boss makes a pass at them and, you know - - -

PROF KING: Agree entirely, yes.

DR BENJAMIN: And it's a totally different condition, and the submission here was saying that it was someone has experienced psychosis, they can't even predict that at age 18. And I'm thinking, well, what can you really tell about kids that are in trouble that the schools don't already know. I remember – look, I was also a bureaucrat in the Department of Education for 10 years, and whenever I put proposals up they just laughed, because they said, “We know all this stuff”.

PROF KING: So schools is what – we're actually talking before you get to school. So agree that teachers in schools know what's going on.

DR BENJAMIN: Let me put it not in my words, because I'm not an expert on this. Allen J Francis cautioned that whatever they say they're going to do, it ends up with drugs, that's basically - - -

PROF KING: Okay, so that's really my question. How do we – because my understanding is there's no need for diagnosis, and certainly not at that age, and there's - - -

DR BENJAMIN: Too early. And the therapies – the other question is, what is the therapy here? Therapies are play therapy. Now, do you need a \$300 an hour gap fee psychiatrist to do play therapy or could you just use some community worker?

PROF KING: But that's not what we suggest. So we're suggesting through the health check, to get the help back to families.

DR BENJAMIN: What I see is what's the help, that's my - - -

PROF KING: I see. We need to be clear on that, okay.

DR BENJAMIN: It's not the fact that the kid is at risk, that's not an issue. I can spot that. What I'm saying is okay, who's the help? Is the help going to be a \$300 an hour person with a gap and a waiting list, and as I said, back in Coffs Harbour where I live, that's what they've got, gap fees, waiting lists and an ECT machine. I've not been replaced, and yet there are people sitting there with PhDs who are ready to roll in and replace. Can't do it, thanks to AHPRA.

You'll find the same thing with the zero to three year olds. They'll say, oh, this kid's at risk. Unfortunately they'll have to drive a hundred miles to join a waiting list and get on the list scheme, and then somebody will come along and say, ah, I've got Prozac.

PROF KING: Okay, so we need to be much clearer that what we're meaning by then the follow up is the psychosocial health care for family and support for the family.

DR BENJAMIN: Yes, exactly.

PROF KING: Okay, take on board, yes.

DR BENJAMIN: And the history needed so we'll get a view, and the reason I've submitted in my written thing, the US Congress hearing called the – profits of misery. Major problems in Texas they had, they had a Senate inquiry. Because what happened was the school counsellors were being used as spotters for bounty hunters to come into the school, get a uniformed official to go to the kid's house, drag them off to the psychiatric hospital, run up a bill for 28 days and then discharge them with a psychiatric label for life.

And the evidence was that there was one psychiatrist who had been ticking these off, and another psychiatrist testified, he said, "Here they offer me an extra 300 grand a year to tick those boxes". Had it not been for that expose, we would have had that here. Why do I say that? Because Four Corners did an expose on it, and the New South Wales Health Department tried to block the ABC from showing it. They did show it, and every parliament in every state here said, hey, we don't want that here.

That was the National Medical Enterprises scandal of 1992, which I've submitted to you.

PROF KING: Yes. Okay.

DR BENJAMIN: So my point is that these things always get abused, the history is there that they get abused, and whatever your good intent will be sabotaged by a lot of big funded interests - - -

PROF KING: And just to take it a step further. Your view, and this is reflected in your submission, is they can't be designed not to be abused. That's where I have the fundamental problem.

DR BENJAMIN: The history is what it is - - -

PROF KING: Yes, I know.

DR BENJAMIN: Like are we ever going to have another war. I suspect we will, because we keep trying to stop war, we all know it's bad for us, and yet, every year they go.

PROF KING: Yes, I guess - - -

DR BENJAMIN: I remember Thomas Sasse came out once here, gave a talk, and they asked him, they said, "What would you do about it", and he said, "I'd need the powers of Jesus, Mohammed and Buddha together to make a dent in the medical profession", and I think you'll find that that's the problem. It is big bucks, and the government's constantly under pressure to do something. That's why I've quoted these. If you really need to say, look, this is too much of a mess, quote it back. That's Josh Frydenberg there who wrote your Terms of Reference, saying your best important policy option is don't do it.

PROF KING: And an important lesson for us – I think we need to be careful against who. So we're reading your submissions, listening to your testimony, my reaction is, ah yes, but we can come up with a system that won't be abused. And I think your real message to us is make sure we don't get caught up in our hubris.

DR BENJAMIN: Yes, and think about the ACCC, because I don't think that they're barred from looking into it. The thing is, I have actually written just this last month a lengthy submission to them reporting certain funding associations as cartels, because it says in the law cartels are illegal and immoral. I showed why these are cartels and why they are in fact disrupting the market.

You heard from the counsellors this morning, about Ms Dawson, and I've got to face it this afternoon, the council is paying for the rooms too, there's no referrals, they won't get any, because I get them because I'm under Medicare. But I don't particularly want to do them all.

PROF KING: Okay, thank you for that. And that has clarified, from at least my perspective, those are your submissions and I understand your position better. Thank you very much.

DR BENJAMIN: Sure, thank you.

PROF KING: Some morning tea won't be there at the moment or it is there. Is the morning tea there, because we need bathroom breaks. Let's just take 10 minutes now for a quick morning tea and a bathroom break.

SHORT ADJOURNMENT

10.59 am

RESUMED

11.10 am

PROF KING: All right, so we'll get started again, and Mr Fornarino, if you would be able to state your name, any organisation you represent for the transcript, and any opening comments you'd like to make.

MR FORNARINO: My name is Aaron Fornarino. I'm a public sector worker for the South Australian government, a final year law student studying here in (indistinct), and I'm also a Facebook administrator for a group called Borderline (Indistinct) on Facebook. So that's a bit about me. I'm here representing myself in a private capacity, I would say. I submitted a written document back in February 2019 (indistinct) to the mental health condition Borderline Personality Disorder. I was diagnosed with BPD, as I'll call it for short, when I was 14. I had a long range of hospital admissions and different medications that I was put on. I used to engage in self-harm a lot. I still have scarring from that, and it's been a very trying time to get where I am now.

I'm incredibly happy I've almost completed a law degree. It hasn't been easy, on top of working full-time, so - but my passion lies also in mental health advocacy and bringing light to Borderline Personality Disorder, which was - thought it was wastebasket diagnosis when I was quite young, and we were often called beyond help and attention seeking and manipulative and all sorts of names. This was by the mental health profession itself, police and ambulance workers. It was very, very difficult to live with that, and that was just me, it wasn't my friends or my family. That's not taking into account all the misinformation they were given about BPD at the time. There wasn't much known, whereas treatment initiatives have advanced quite a lot over the last decade I've noticed, which is great.

There's more services available but they're all full - at capacity. So, I wanted to discuss just briefly an administrative matter with the report that I noticed in volume 2, page 804.

MS ABRAMSON: Did we make a typo or misquoted you?

MR FORNARINO: I think quoted as saying bipolar disorder instead of borderline.

MS ABRAMSON: Our apologies for that.

PROF KING: Sorry about that.

MR FORNARINO: No, no, that's okay, it's just (indistinct).

MS ABRAMSON: No, it's a big report and sometimes these things happen, so our apologies.

MR FORNARINO: It is, yes, it is, but - no, no, that's okay. I just wanted to raise that. So, in the submission that I wrote I discuss on early intervention and prevention. What concerns me about schools in particular is that with mental health disorders that they're quite difficult to pick up when you're an adolescent, or they get dismissed quite easily - I know I certainly was - and a lot of problem with school curriculum is that it's rushed, and if you're quite behind or not keeping up the pace it's often dismissed and you go not knowing, or not learning a particular area. That was one issue that stuck with me that I remember from my school years.

So, I struggled in school, but mainly because when I hit adolescence I was in hospital quite a lot. It's just it was impossible to try and study while I've been on all sorts of different psychiatric medications. A lot of these medications have very horrible side effects. I didn't learn of a condition called akathisia until I was quite late and where I had really bad nervous reactions from the medication that was given, and it was dismissed as bad behaviour when it was actually a drug reaction, so that's quite concerning. It's quite rare, so I - if medication works for people that's great, but it didn't for me and I haven't taken medication for quite some years now.

There's a lot of investment by the federal government in youth mental health, particularly towards Headspace. I think Headspace do a fantastic job to a certain degree. I think they focus primarily on depression and anxiety in youth, but a lot of the more complex mental health disorders go ignored or there's not as much support available. That was certainly the case when I was young, and from what I've heard people over, I think it's 24 - so if you're 25 or over you really struggle trying to find treatment options that are quick and can assist you. So, with stigma in general, I read the discrimination section in the report and found that was quite interesting.

I reviewed the study that was quoted; I think it was by Morgan (Indistinct) 2016. It concerned me that what (indistinct) was used, primarily because it claims that 11.8 per cent of the respondents only reported discrimination, but when I reviewed the table that they've outlined - I think it was on page 758 of that article - they've got a weighted table of mental health problems, but the two primary disorders on there are depression and anxiety, including PTSD and OCD, but then there were listed bipolar, psychotic, eating, and personality disorders in (indistinct) minority, but at the same time they've sort of quoted multiple diagnoses were possible.

So, it sort of stuns me a bit that a table like that can be used, but it's not very specific and it makes it look like depression and anxiety are the two biggest factors of what were their study for discrimination, which I don't really agree with because from my experience and from a lot of others who I've talked to with BPD - as I said, I'm a Facebook administrator so I interact with people with BPD quite frequently, and many complained of discrimination and poor treatment, especially in emergency departments, particularly here in South Australia, which is concerning.

PROF KING: Sorry, can I - you raised a good point on - and I can't remember the details of the article off the top of my head, so apologies, but there would be an issue if they've done a survey of people with mental health issues, because we know that in terms of prevalence mild anxiety and depression are by far the most common, so it could be quite possible to get their results if you're saying, well, if you can - if you do it over the whole population and you've got - a large part of that population is a group with very low - low or mild intensity and symptoms, so they don't face stigma, but there's another group up here that may 100 per cent face stigma, and you can still end up with a low number simply because you're not focusing on the right group. So, do you think that's a proper way of interpreting what was happening there?

MR FORNARINO: Considering personality disorder is last - lastly ranked at 1.2 on the table - I think, yes, it is quite a minority, but a lot of people with personality disorders experience discrimination, and not just BPD. It's a whole range of (indistinct).

PROF KING: Yes. No, agreed. So really the issue is that it's not sensible to talk about stigma and discrimination over all mental ill-health. It's necessary to think about a degree of severity.

MR FORNARINO: Of severity.

PROF KING: And diagnosis, and I want to come back to diagnosis, but apologies, I intervened.

MR FORNARINO: No, that's okay. Some other things that have been concerning over the years as I've been growing up looking at how BPD has been treated, is just some attitudes between politicians at federal and state levels. A lot like to football health between one another so to speak, as in it's a state attitude as - sorry, a state issue, like that sort of attitude, whereas you go on the telly, ABC Question Time, and you look at politicians engaging in rather bullying and concerning behaviour but telling teenagers bullying is not okay. That concerns me. It just sends a mixed message that I think is quite wrong.

Peer working has been an interesting area. I work full-time in taxation matters for state and state-based tax, and it's a rewarding job and I enjoy working with the public, but it's (indistinct) and I can earn money through doing my work with the government, but at the same time there's not much incentive for me to go and - I mean, despite a lack of incentive I still do go out and speak about BPD. I've presented at a couple of interstate conferences over the last two years, which has been great. I've engaged in BPD services and offering an opinion, but it - the peer work sector is very poorly funded. For something that's very essential and crucial to assisting people with mental health issues that - I find that sector very competitive and very low paying for how important it is. I would like to see some sort of initiative towards lived experience, which is really important.

This year I attended an interesting session run by a group called Acrofyre. They assist prisoners in their release and transition between prison and back to - back into the community. What I found interesting is that a lot men with BPD are either misdiagnosed or not diagnosed at all, and they receive nothing. It was often in the quotation of 75 to 25, with 75 being women and 25 being men. While that may be statistically correct for those who are diagnosed it doesn't mean by any stretch that men with BPD aren't out there. There's no many services for men. Men have that additional layer of discrimination just by being a man. BPD is considered to be a very - I'm not saying I agree with this, but a very dramatic, sensitive illness and you have men that have been taught to be resilient and to hide your feelings pretty much, which compounds a very big issue, and I wouldn't be surprised if there was a good proportion of men who do commit suicide because they just - they can't get help.

They either don't want to identify they have a problem and they commit suicide, or they attempt to seek treatment and end up committing suicide anyway. I've had several friends over the years that I've lost to suicide. It is really a difficult area. It concerns me a little when I see campaigns talking about suicide prevention, zero targets for suicide, when as I said earlier, depression and anxiety have become more prevalent as mental health disorders and talking and education has come a long way in the last decade at least, but for the more severe type illness they're still taboo, they're still not spoken about very much. That concerns me and it concerns a lot of the people that I've worked - I try to work with.

One thing in particular for me is that I (indistinct) medication didn't work well for me. It does for some but I think there's an over reliance on medication for people with BPD. I met with a community cabinet area in 2011. I met Nicola Roxon under Prime Minister Gillard's government and Mark Butler, I think, was the mental health minister at the time, and I discussed about issues relating to the Better Access to Medicare scheme, or ATAPS I think as it was then, because they've reduced the amount of services provided to people to seek psychological support. I was told pretty much that it was a short-term measure, that the actual Better Access to Medicare scheme was never intended to replace full-blown psychological support, but I was told it was a temporary setback, but here we are in 2019 and the sessions still haven't changed, so it's - I'm not sure what's happening with that.

It's been really rewarding being able to work with people with BPD. From the talks that I've given and the feedback that I've received over the years, the last - because I've only really been doing advocacy work for the last three years. I needed to be in the mind space where I could do it, because it is very demanding and it can be very confronting, but to hear some of the positive feedback that I've received, it's been great. It's just difficult when you get someone that comes to you with a problem and you want to have all the time in the world to listen to them, but the practical reality is you don't. You can't, and it's hard because you don't have many options you can offer either.

It was concerning to see that eating disorders got given a 40 session boost with that access scheme, but ironically many with eating disorders also have BPD, but it shuns men to a certain degree because women are more likely to have eating disorders than men. Not saying they don't happen, but they do. I mean, it still sort of limits - I look at it that you could really kill two birds with one stone if you expanded that 40 session to BPD, not just eating disorders. It would have captured a lot more people and would have been a lot more beneficial.

Just going back a little bit to stigma, many thought BPD was a load of rubbish, a load of nonsense. That's very disheartening if you're diagnosed with that sort of condition because it is very intense. You do self-harm a lot. I've had two serious suicide attempts in my lifetime where I've almost died, and to have someone come along and say "Well, you don't have a mental illness". It's not a mental illness, it's a personality disorder, and then to look at media attitudes towards BPD in particular, and reporting on them when it's usually in the context of criminal offending, where some defendant has used their BPD as trying to receive some sort of mitigation.

There was a recent case in Victoria last year I think where personality disorders were now considered to be a worthy mitigating factor. I'm not really happy with the case that was used for that, because it involved a really graphic murder. I don't think personality disorders should be used as an excuse for acts of violence like that, but at the same time for minor type offences, to get someone on track and in help in therapy mitigation should be used. The role of social media in discussing mental health, with things like Facebook and Twitter and whatnot, are sometimes a really bad platform for discussing these issues.

You get comments from a variety of the public, often calling mental health as bleeding heart defences, particularly with criminal cases; "Oh, they'll just get let off. They'll claim they have a mental health issue when they appear."

It's hard to read stuff like that because mental health really does affect you as a person, and sometimes media only report on one side, which is usually the victim's side, which is fair enough but there's very little reporting on - at all on the offender or their circumstance or their background. I often read sentencing remarks to the courts here, and it's quite interesting, in 2017 I - I often Google BPD just for the sake of it, to see what sort of study is going on or if it's progressed - if anything's progressed, if attitudes have changed, and I came across a court hearing here in South Australia run by the Coroner's Court, and it was over the deaths of two young women who committed suicide from BPD, and their treatment - very poor treatment, I should say - and I actually took time off work and sat in each day to listen to the coroner, and I just found myself shaking my head constantly.

The descriptions of what these two young women went through I identified with very strongly, and it was really upsetting, and the whole reason I went to that hearing is I figured as a law student, if I could sit through something like that, something really personal to me, then I can do anything really. I can - I'll be able to handle anything in that area, but it was really concerning to hear their treatment and just being able to identify with their poor treatment. I've engaged with psychiatrists before I commenced this advocacy work, usually often in a distressed and agitated state where they'd be debating whether BPD was a psychiatric disorder or not, and would use that as a basis to discharge, saying "No, it's not", and that's horrible.

My poor family, I feel sorry for at having to come and pick me up at 2 am from hospital as a teenager because I had nowhere to go. I was discharged and that was it. That's - that was really difficult for them, and being fed all sorts of information like I was just an attention seeker. I read a document from a psychiatrist saying that I could switch my symptoms on and off. It doesn't work like that with BPD, not at all. There are very bad issues with impulsivity, very severe issue with impulsivity that wreak havoc with your decision making abilities, and I think people don't understand that. They think it's a conscious choice to act out and there's no ability to stop - sorry, there's an ability to stop when there isn't. A bit beyond that, so I would like to see more federal funding towards BPD. I don't think it goes far enough, not at all.

I assisted SANE Australia with a peer - sorry, a treatment services report and we were looking at just the general treatment services all over Australia, and it's very poor, very poor if any. You have certain, like, state run services, like Project Air in Sydney, and they do a lot of great work. Brin Grenyer, he heads that, and they really expanded their program over there, and I would consider it very successful, and a few years ago when we had the state election here the ministers from both parties announced a BPD centre for South Australia, which was a great first step, and I think it was a consequence of the coronial inquiry. So that's up and running, but it's still very slow, a very slow process.

It's great to see that there've been advances towards mental health, but at the same time it's incredibly slow, and I think there's a lot of mental health issues and concerns that aren't raised, that are avoided, and there's a lot of focus on depression and anxiety. We're now not the be all and end all of mental illness.

PROF KING: Can I ask you - sorry, but can I ask you about the stigma by the medical profession, because we have heard, and indeed not just from people who have lived experience but also from clinicians themselves, that there are psychologists and psychiatrists out there who will not deal with, refuse to deal with, will shunt off anyone with BPD, and I find that concerning. I mean, it's an issue of stigma, and I'm wondering is it getting better, is it getting worse, is it about the same, and I don't know what we can do about it when the actual professionals themselves, who should know better, behave that way.

MR FORNARINO: You would think that, that it would have gotten better. I - from some of the stories that I've heard of, being an administrator, it appears on face value not much has changed, if any, particularly when trying to seek help, like trying to seek a psychiatrist and being told "No, I don't work with people with BPD", or something similar like that. I say it hasn't progressed that much. I mean, it is a bit different now because we do have a centre that sort of specialises in that, but at the same time I'm concerned that the centre only deals with very severe cases, rather than just generalised BPD.

PROF KING: Yes.

MR FORNARINO: Trying to seek help with BPD through a psychiatrist is incredibly tiring. You end up ringing around psychiatrist after psychiatrist hoping to get an appointment. Appointments are often drawn out so you're waiting months, and even DBT services, which are dialectical behavioural therapy, those services have, like, two to four years wait lists, which is crazy, that long to get into that evidence-based treatment. I've done DBT twice. It's really helped me. I was lucky to get in twice when I did, but I did, and for others, watching them wait, it's exhausting.

PROF KING: So is that just - sorry, just on - - -

MR FORNARINO: And they're trying to - - -

PROF KING: Just on that, is it for the - for dialectic - I can never remember the acronyms - this dialectic therapy, is the waiting list issue related to publicly funded or bulk billed services versus services with a significant co-payment, or is there just waiting lists for all services?

MR FORNARINO: I think it's both. I think both public and private are maxed out to their capacity.

PROF KING: Okay.

MR FORNARINO: I know someone recently was looking for private services because they were that desperate, and I attempted to locate one but they advised that they were full, and they couldn't take any more on. So, DBT is very cost effective in terms of ongoing health costs, which has also been an interesting issue over the years, to - we've tried to say to politicians that "Look, if you invest in this area for a modest amount of money you're overall going to reduce your health costs, and not just health but police, ambulance, all those soft services. You can save on costs if you invest in this." That was met with dismissing attitudes when - over a few years ago, when I first started enquiring about this.

It defied all logic that "No, we won't run a BPD centre in South Australia" by some political entities, when finally they have. I'm hoping that they do see a benefit over the long-term, but it is well worth the investment, that you do actually save money by treating this disorder, and it can be treated. You never fully recover from BPD. It's like I still have my bad days. I still - like anyone, and I guess that's what sometimes people don't understand, is that people look at the diagnostic criteria of BPD and go "Well everyone feels like that. Everyone has days where they - that they're up and down and all over the place", and it's like, well yes, but not to the severity of someone with BPD. The emotional intensity of BPD is horrible. It's - you go on very bad mood swings and it's hard for those around you to see that.

It's like with police and ambulance. They deal with you for, I don't know, two or three hours and then they go, and then they don't remember you. They don't see you when you're beyond that distressed state. They don't see that you actually function okay and work, and that is possible, but I just think more education around the overall health sector about BPD is required. There's a lot of bureaucratic red tape and competition as to who can provide those services, which I don't really agree with, but there is definitely more education and treatment that needs to be done in this area, and I think it's only really just scratched the surface, if that makes sense. I don't think it's to its full potential with treatment options yet.

PROF KING: Can I just ask one last question from me? Apologies I'm sort of hogging it a bit, but you had a diagnosis in your teenage years. That then led to - that led to a lot of stigma and so on. Was the diagnosis helpful? And this is again coming back to something that you may have heard me mention earlier on, but there does seem to be differing views in the professions about whether a diagnosis is actually helpful or not, and it seems to - my perspective - I'm not a clinician, so it seems very confused from my perspective. Does a diagnosis help? In your case did it help?

MR FORNARINO: I'll just touch on the name briefly before answering your query.

PROF KING: Yes.

MR FORNARINO: The term Borderline Personality Disorder, the first thing that people think of when they hear that term is "Borderline of what? What are you on the

border of?" and then they see personality disorder. There's nothing disordered about my personality. It's just a term that's been thrown together.

PROF KING: Yes.

MR FORNARINO: A very outdated term, and the substitutes for it aren't too much better, like Emotionally Unstable Personality Disorder. I cannot stand that. That's just as bad as BPD. But me aside, having a diagnosis, for me, I suppose at the time when I was given it - I mean, I was given the term BPD by a very competent and skilled psychiatrist when I was 14.

PROF KING: Yes.

MR FORNARINO: There's not many, if any, psychiatrists who would do such a thing nowadays I don't think, or feel comfortable with giving a 14 year old a diagnosis of BPD. I was, and it turned out to be correct, but for me a diagnosis was a bit eye-opening and shocking. On one hand I felt relaxed and comfortable that I knew that there was something wrong, that it wasn't all in my head, it wasn't made up, but at the same time you'd have all these opposing views from mental health professionals who thought it was a load of rubbish.

PROF KING: Yes.

MR FORNARINO: They thought it was a wastebasket diagnosis and wouldn't treat you, and would make you feel excluded. It was just stigma - it's stigma all the time. So a diagnosis, while helpful in assisting my understanding of what I was going through, I can see to a degree how it wouldn't - may not be for some, because it's like "Well I've got a diagnosis. Now what? What do I do? Treatment is like two to four years away." That can be really confronting for some people, and I guess it all - it's all very subjective how a person feels on that type of diagnosis. I mean, some people get diagnosed with PTSD, which is very similar. Some people get diagnosed with bipolar, maybe wrongly or rightly. My concern is a heavy overreliance of medication.

PROF KING: Yes.

MR FORNARINO: And just medication, while it can assist in short-term issues with BPD, it does nothing long-term. That's what I've found for me anyway. I'm aware of a few - or at least one new drug trial by a company called Orison, I think, which has shown promising results for BPD. They've tested that on Alzheimer's I think. It targets an aggressive component of BPD and it's been very promising, so I look forward to reading that in future.

PROF KING: Do you have any questions?

MS ABRAMSON: I have one question, and also can I thank you for appearing today, because the lived experience really matters to the Commission, so that you've had the

courage to do that, thank you. What would have made a difference to you in school? Because one of the - you'll know we've got a very heavy emphasis in the report about providing support services for children and youth when they're in the school system by connecting outside.

So, I was interested when you said – and congratulations for going back to do law because I tell you, things like property law are boring at the best of times. So, well done, you. But what would have made a difference to you, do you think, or would nothing in the school system have been helpful?

MR FORNARINO: The problem with me is it wasn't just school; it was a variety of issues.

MS ABRAMSON: Yes.

MR FORNARINO: But school in particular, bullying was a huge issue. That's why I'm very interested in bullying and the effects and mechanisms schools use to deal with bullying. That affected me a lot. I'm not sure that there was much that could have been done. I mean I started showing signs when I was probably 10, 11, of just depression and isolation and wanting to be alone. I don't attribute that to the school system solely but it certainly didn't help. As I was saying earlier, this mentality of – well, students have a set curriculum. You've got to learn it or you lose it. That's a really bad problem and it's never revisited if something happens in a child's life. They've sort of missed that opportunity to relearn. I mean I don't know what school is like now but when I was growing up it really was you either learn it or you don't, and if you don't, that's, "Too bad. We're sorry".

MS ABRAMSON: We're very concerned. I mean congratulations to you, to be honest, getting back and getting to university because we're very concerned about students who fall out of the system all together. We're concerned about them inside but their prospects are so much worse in terms of employment and other things. So, we're open to any sort of creative suggestions on that front.

MR FORNARINO: Well, that was like with employment. I think I wrote about in my submission. I mentioned a New South Wales case.

MS ABRAMSON: Yes.

MR FORNARINO: (Indistinct words), where people need to be encouraged to apply for a job. They see a question like, "Do you have any medical disability that may affect your capacity".

MS ABRAMSON: Yes.

MR FORNARINO: I think that's really important to raise awareness in the mental health area that, yes, you can have a mental health issue. You need to assess whether you

feel like it's going to affect your job or not. By ticking "no" you don't on the box is not necessarily dishonest. If something hasn't affected you, then you should really apply for work. That stops a lot of people from what I've heard and from whom I've talked to. They're terrified of applying for work because they see a question like that and they'll flat out refuse.

MS ABRAMSON: Yet the strange thing is, and it's not perfect by any means, with a physical disability the employer is inclined to ask, "Well, what practical things do I need to do to accommodate your disability". I know that's not universal.

MR FORNARINO: No.

MS ABRAMSON: Mental health is just treated very differently.

MR FORNARINO: It is.

MS ABRAMSON: Thank you. Thank you so much.

MR FORNARINO: Thank you very much.

PROF KING: Next, Morton Rawlin, and if you're able to state your name, any organisation you represent for the transcript and any opening comments like you'd like to make.

DR RAWLIN: Thank you very much. My name is Morton Rawlin. I'm a GP. I practise in Melbourne but I also have been a rural GP in the past. I am the chair of the General Practice Mental Health Standards Collaboration, which is an organisation funded by the federal government to look at the standards of the training of GPs to access the Better Access Medicare rebates.

PROF KING: Yes.

DR RAWLIN: The committee is in many ways unique in that it has representatives from the two general practice colleges, the psychologists, psychiatrists and, more importantly, consumers and carers who have active input into the standards. As an organisation, we have trained approximately 90 per cent of vocationally registered GPs and particularly fair access around high prevalence disorders which, in other words, is depression and anxiety. We would love to do some work in the lesser prevalent disorders, such as BPD, but that's not within our remit at this point in time.

I also have served on the College of GPs College National Council in the past, but the other thing that I do is I'm the Medical Director of the Royal Flying Doctor Service in Victoria. So, I'm connected in from that perspective as well.

MS ABRAMSON: You're very busy.

DR RAWLIN: Yes. Thank you. We have provided a submission.

MS ABRAMSON: Yes.

DR RAWLIN: I take that as standing. I guess the main things that I wanted to highlight were just some, for want of a better term, anomalies in the Medicare systems which tends to cause some issues for general practice. There are a significant number of GPs who are additionally trained in mental health over and above the level 1 mental health training who have additional skills, who do like to do mental health, who are interested and do like to engage with their patients. The difficulty for them is that if they actually treat people under the Medicare GP mental health items, that reduces the amount of access that those patients can get from psychologists.

PROF KING: So, cancer is one of the 10?

DR RAWLIN: That's correct. My particular interests are in CBT and I also do medical hypnosis. If I then bill the item number as an FDS provider and I also am working with a psychologist for the same person, we jointly have 10 items that we can do, but it may be better for us to have more, so that is an anomaly. What normally happens is I bill under a time-based normal consultation which means it doesn't show up as a mental health provider which falsely reduces the perception that GPs actually do treat mental health because we do.

I think that's one thing that if those two areas were uncoupled, that a GP with a particular interest and standing, and we do have the ability through the GPMHSC to regulate that and the training needs for that. If those two were uncoupled, patients would ultimately benefit because they're going to get good service from their GP, as well as from their psychologist. But also, as a bigger picture in the system, you'd actually be able to identify where some of that money is actually going.

PROF KING: Yes.

DR RAWLIN: At the moment it's just in the main pool.

I guess the other issue that has come up in the reports to date is the usefulness of the mental health treatment plans. I guess my comment to the Commission about that is that the perception of what a mental health treatment plan is for needs to be really clarified. The mental health treatment plan is really a guided way to guide the GP through the diagnostic process in the mental health setting. It's actually not the referral. I mean I do a lot of mental health plans but not all of them go to psychologists, not all of them go to psychiatrists, also, I don't always bill them. But it's an issue that it's a way to help the diagnostic process, making sure the doctors are aware.

One of the problems, and this is the same across Australia in many other specialties, is that in general practice we are a broad church. We have different ways of being trained. There is a large number of GPs who are trained overseas who have different views,

different training around mental health. I think the Australian graduates get definitely a better approach taught to them. I do try very much – I’ve been involved in GP training for a long time – to try and teach that as part of the process. Certainly, our registrars get training but not every GP has had training in terms of being registrar, as the international medical graduates are.

PROF KING: Can I follow up on just the mental health treatment plans?

DR RAWLIN: Yes.

PROF KING: Because in theory, as you said, it’s a broad church, so in theory they should be more than a referral and a part of the diagnostic tool.

DR RAWLIN: Yes.

PROF KING: But we have seen examples of mental health treatment plans. The one that sticks in my mind was one that just had the one word on it which was “depressed” and that was the entire treatment plan.

DR RAWLIN: Sure, yes.

PROF KING: Is there a way, and we obviously ask for more feedback because for a non-trivial number, I would say a significant number of GPs, they don’t have the strong interest in the area.

DR RAWLIN: No.

PROF KING: It is just a box ticking exercise that they go through, if I can call it that, to be able to get a referral on to the next stage of treatment. But then there are also GPs who do an excellent job with the mental health treatment plans and it differs. I wonder though, given that spectrum, is it better from a GPs perspective – let me give you an example. If I have a broken leg or an injured body, I go into a GP. The GP says, “Well, I’m not sure. Go and get an x-ray”. So, I go off, x-ray is back, now I see the doctor and the treatment goes ahead. Would that be a better approach for mental health in general, given the broad church of GPs, so that in a sense there’s the GP who would say, “There’s something going on here. I think it’s a mental health issue”, rather than the GP themselves trying to in a sense do a mental health treatment plan which is diagnostic or CLISI diagnostic.

There is a triaging service or there is another group of professionals, and the one that I’m thinking of is in WA, with the PORTS service that they have over there. Given the distances in WA it makes a lot of sense, the GP says to the individual - in a sense, refers them to PORTS. PORTS make contact with them within 24 hours, often through a phone contact, and then there is a more formal triaging to work out what direction we need to send you in next.

DR RAWLIN: There are a couple of parts to that question.

PROF KING: Sorry, it's a long question. I didn't mean it to be so long.

DR RAWLIN: No, no. I think it's a very relevant question. There are a couple of issues; one is around the GP's knowledge of the support services in their local area.

PROF KING: Yes.

DR RAWLIN: Some GPs may not be aware of all of the appropriate services, particularly for very specialised areas of mental health. So, that's one place where a diagnostic or a referral in the middle type process may help.

PROF KING: Yes.

DR RAWLIN: Now, theoretically, the primary health networks are supposed to be in that spot. Currently, I have to say that many are not, some are but many are not.

PROF KING: Yes.

DR RAWLIN: I think that from the general practice perspective, the critical thing is to make a decision about whether this person requires some support, and the mental health treatment plan helps the doctor to do that. Now, one of the problems and I can be accused of that from time to time, is that our notes perhaps are not as good as they should be. However, our referrals in terms of writing the referral should in fact be a lot better.

One of the problems I guess in mental health is that a lot of the mental health information is quite complex and to actually put it into a document in a 15 or 20-minute consultation, is actually really hard. Many of my referrals are quite brief; however, I actually ring the psychologists that I work with and have a 10-minute conversation with them about the background, what I found, what I'm doing with the patient and what I think they would benefit from.

PROF KING: Although I would suggest that that is not common practice.

DR RAWLIN: No, and I agree with that but I think the issue there is that there are ways to do it but the mental health treatment plan tends to focus the doctor a little bit in that it's not like a normal consultation or it shouldn't be.

PROF KING: Yes.

DR RAWLIN: I think there is a lot of work that we can do around making the process better, but I think having a DSM diagnosis in many ways can be counterproductive in a whole raft of things because mental health changes. We all have times when we are not good. We all have times when we're pretty good. When I'm bad I could be perhaps labelled as depressed, when I'm good, I wouldn't be. But the issues are if you do put a label on somebody, it is a label and it does come with consequences.

I certainly have patients who are very clear when we talk about these things that they do not want things on paper for various reasons. I am more than comfortable that that does not occur. I have had certainly personally patients who have been denied access to insurance, their superannuation and things like that have been affected. Their travel has been affected and their job opportunities.

There is a whole raft of reasons why a treatment plan may just have “depressed”. I would hope that there is a lot more on it but the diagnosis of depression is quite a broad one. There are people who are just a little bit melancholic, there are people who are severely and suicidally depressed and the treatment for both is very different.

The other bit that I would say is another issue for general practice, and following on from suicide prevention, is that a lot of the newer abilities for support for people with suicidality and suicidal ideation are actually quite good in that they are getting personalised support and all of those sorts of things. The problem for us in general practice is that in order for our patients to get access to that, we have to send them to the emergency department.

That is one of the worst places to send somebody with suicidal ideation. Even if you actually ring the emergency department and say, “Look, this is what’s happening. They need this, this and this”. I’ve rung the team. They are going to send somebody. If the team isn’t there waiting for them at the front desk, it is a nightmare.

PROF KING: Sorry, I just want to understand exactly what drives that. Is that for legal reasons if someone presents to a GP and says - - -

DR RAWLIN: No, the services are not able to be accessed through general practice. It’s as simple as that.

PROF KING: Okay, yes.

MS ABRAMSON: I’m just mindful of the time.

PROF KING: All right. My apologies. I’m mindful of the time. Thank you very much.

MS ABRAMSON: Thank you very much.

DR RAWLIN: No worries.

PROF KING: Ms Leanne Longfellow.

DR LONGFELLOW: That’s me. Hello.

PROF KING: Hello, if you’d be able to state your name and if you’re representing an organisation, which organisation and any opening comments that you’d like to make.

DR LONGFELLOW: My name is Leanne Longfellow. I'm not representing any organisation. I read the report through the lens of family experience and that's what I'd like to share today. I work in the area of disability, with children with disabilities and I have a PhD in that area. This is about it really destroying my brother who had schizophrenia and other disabilities and moved interstate. Just to paint a picture of him, he was diagnosed with schizophrenia when he was a teenager and in and out of hospital and really couldn't care for himself. He was on a disability support pension and lived in Housing Commission. He needed help with basic skills.

I thought everything was fine up until last year. So, I had been unable to make contact with him. He didn't use the internet. He only used the phone and had been unable to make contact with him by phone, and I was a bit concerned about this. At the time, my own daughter was in intensive care so I did put it on hold for a while. On the day that she got out of hospital, I rang the police and also my brother had, and I must be really clear about this, I thought he had a whole lot of support. He had different organisations because he couldn't look after himself. He was an NDIS recipient or I thought he was; he certainly had been. He had all these different organisations and it involved in home care.

When I wasn't able to make contact with him, I thought everything would be okay because someone would ring because there are people going in to the house. So, I rang the police, and this is interstate. That night at 10 o'clock, two police knocked on my door and told me my brother was dead and had been dead for two months. I can't convey how distressing that is and for me to try and understand as the only family member left, to understand how when you think someone is really well supported and they're not and all his services had been cut off. We're talking about someone who couldn't make a meal and had other disabilities.

Since that day, what I have done is I have contacted every organisation, obtained a verbal account from each one and, where possible, a written account. I've obtained his medical reports. I've spoken with the NDIS, obtained police statements. I have become executor of my brother's estate so that I can do all this. I have obtained information from the coroner. They were unable to do an autopsy because of the state of his body, so I will never know how he died.

What is startling is that policy was followed. Policy was followed and we've got someone dead on the floor for two months. I just don't understand. I want an inquest. At this stage, it's not clear whether there will be an inquest into his death but what I can see from my reading of my brother's notes, I believe there were three key problems.

Firstly, the interaction between mental health services and the NDIS because both of those were cut off. Mental health services claim that it had nothing to do with my brother becoming an NDIS recipient, but I don't understand how someone who at 35 years had nurses in his home and social workers can suddenly decide, "Well, you're doing okay". This is someone who occasionally live in his back yard when he was in psychosis. He

couldn't look after himself. Why would that happen? His NDIS was cut off because he didn't go to a meeting, so that was cut off.

For 35 years he had care from a hospital and he had case management, but with the NDIS there was this really fragmented service delivery and he didn't have case management. I thought he had case management; he had a support coordinator. They do not do case management. But someone like my brother, who can't look after himself, needs case management.

When I was reading the report, what really bothered me is this notion of economic participation and enhancing productivity and economic growth. They're the words used in the paper. There are some people in our society who are never going to work and they still should be valued. They still should be valued.

MS ABRAMSON: I don't think there's any disagreement from the Commission on that.

DR LONGFELLOW: I certainly think in our society – the premise of the NDIS is based on people contributing and I did feel that a bit in the report, that that was the case and that we need our society based on it and valued on it.

Certainly, after my brother's death, when I was trying to advocate for him, I felt that there was a lot of stigma around disability. The way I was treated, I was treated with enormous disrespect by some organisations. I will say the NDIS were very helpful, they were very helpful. Others were not. An example is the police asked me to – I flew over to organise a funeral for my brother, once his body was released from the coroner.

The police mentioned that they wanted a statement from me and, as his only relative, you would think that would be an important thing, and the only person who had contact with him. When I arrived at the police station, they told me to get in a line and I waited for hours, alongside people who had lost their mobile phones. When they finally spoke with me, they said, "We're too busy to take a statement". I'd flown from interstate. This was on a Friday and they said, "Come back on Monday". The same thing happened on Monday. They never got a statement from me until I made a complaint with the police.

It just wasn't considered an issue by a lot of people that someone is dead in the house for two months. It just – I mean (indistinct words) and distressed me but it just wasn't. I know the death rate of people through the NDIS or statistics that were released for a three-month period are a very high number and not all were due to the NDIS and some are natural causes. But my brother is one of those people and even though it's not deemed as being related to service provision, it needs to be looked at, it really, really does.

People like my brother need case management. When I've gone through this fragmented service delivery, all these different organisations that were involved, but none of them spoke with the others. None of them really knew how to support him. Actually, they all

told me that the NDIS plan was about getting him work. He would never go to work. He had numerous disabilities. He couldn't look after himself.

MS ABRAMSON: Did he have any community nurse attending him because a lot of the people in this cohort do have someone that comes regularly to check on their medications, et cetera?

DR LONGFELLOW: He did have that. He was under a hospital. He was under Concord Hospital in Sydney.

MS ABRAMSON: Yes.

DR LONGFELLOW: Then they thought that he was doing very well. He was discharged to a rehabilitation centre and they said that he was doing well. I obtained all the notes. They said that he was doing so well he was discharged, but on that form, it's all incorrect. They said that he'd never tried to commit suicide. He would regularly try to commit suicide. They said that he wasn't isolated. My brother was so isolated. I was the only person who spoke with him. He had one friend in the whole world, so I would fly over once a year with my brother. I spent time with him in December 2018 and saw him face to face. I spent over times over time.

In December 2018 I said to him, "How is your friend, Brian" and he said, "I haven't seen him". After my brother's death, I found out that Brian had been dead for two years. We're talking about someone incredibly isolated who couldn't look after himself and had no connection, and the box was ticked that he wasn't isolated.

MS ABRAMSON: How could we improve that process because one of the concerns that we've certainly had raised with us is that loved ones, when someone is admitted to hospital, the hospital often says for confidentiality reasons they won't share the treatment plans or the notes. Yet when you actually ask people who worked in the sector, they say that having the conversation in the right way with the patient, you very often will get that consent. So, would something like that have made a difference to you if you had been able to be involved like that?

DR LONGFELLOW: Yes, I think one of the other things is the complexity of it all because – I'm just not sure. I thought – I talked with my brother about him having support coordination and I thought that's a great thing.

MS ABRAMSON: Yes.

DR LONGFELLOW: But it wasn't until after his death that I found it wasn't what I thought it was.

MS ABRAMSON: It wasn't a personal interaction, it's a back-office thing of putting things together. But you assumed, I guess, and you correct me if I'm wrong, that someone was actually going in and knocking on the door or ringing him.

DR LONGFELLOW: Yes, yes. I thought he had human support.

MS ABRAMSON: Yes, because he had pre-NDIS?

DR LONGFELLOW: He had it previously and it was all removed. I just don't understand. I mean to me is that economic restriction. Why do they do that? It must be. I certainly hope there's an inquest into my brother's death. I think we can learn a lot from this because I've also been told my brother is not the only person this has happened to. It's unacceptable; it's just unacceptable.

MS ABRAMSON: We have not particularly looked at NDIS because it was outside what we're going to look at, but your evidence today is a very important reminder for us and thank you for sharing it with us. Sorry for your loss. It means that we have to think very carefully about what our care coordinators would look like. It's not just a back-office function. We'll have to think about how can we be sure that people are actually interacting as they need to be.

PROF KING: Yes, and also linking up the information.

MS ABRAMSON: That's right.

PROF KING: The idea that the rehabilitation centre could have just have what are effectively the wrong medical records is frightening and it should not occur. We should have a system that links up the information, otherwise people will make the wrong decisions and we know there's fatal consequences.

MS ABRAMSON: True, but one of the difficulties would be that with your brother's information it's the cross checking and if someone has an acute disorder, then they're not on their game to say, "Well hang on a minute, is that right", so that's the other issue.

PROF KING: Yes. Things like attempted suicide, it should be recorded somewhere.

MS ABRAMSON: It should be recorded somewhere in the system, yes.

PROF KING: It should be recorded somewhere. It shouldn't necessarily be an individual's – "Well, have you attempted suicide?" "No."

MS ABRAMSON: No, no, I understand. Was there anything else that you wanted to talk to us about?

DR LONGFELLOW: Just the last point is to really drive home that NDIS don't provide mental health services because I think when I was speaking with different people from the rehabilitation centre and the hospital, they all said to me, "Your brother was receiving NDIS". I said, "Well, was that the reason why his mental health services did not

continue”, and they said, “No”. But why mention that and why was he discharged? It doesn’t add up.

MS ABRAMSON: No. Well, one system didn’t see what the other system was doing for him. No, I understand.

DR LONGFELLOW: Yes. So, to me there’s lots of gaps and I think that interface between mental health and NDIS and how to handle care management. For the people at the pointy end to mention NDIS, like people can’t look after themselves. I have a lot of guilt because my brother was interstate. I thought about bringing him out to South Australia but I actually thought he had good service provision where he was. For me it’s gut wrenching that I wasn’t aware that he wasn’t receiving good service provision.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you for being courageous enough. It’s no comfort probably but we’ve listened very carefully to what you’ve said to us, so those are some of the things we will think about in terms of our work, so thank you.

DR LONGFELLOW: Thank you.

PROF KING: Thank you very much. Next, Sally Tregenza, and if you can just state your name, any organisation you represent, and any opening comments that you have.

DR TREGENZA: Okay, thanks. My name is Dr Sally Tregenza. I’m a psychiatrist working in the public mental health system in South Australia and I’m here representing the Royal Australian and New Zealand College of Psychiatrists and, in particular, the South Australian branch of the college. The branch works as a committee sort of responding to mental health issues that are relevant in South Australia.

I guess we see the college’s role as advocacy in the mental health space, representing the view of psychiatrists. Often, we do get feedback directly to our branch from other psychiatrists or the general public or GPs around difficulties with accessing mental health services and problems in the system.

The college has formally responded to the Productivity Commission with quite an extensive response, but I thought today was an opportunity to talk about a few points but particularly South Australia. Would you like me to just sort of start?

PROF KING: Yes.

MS ABRAMSON: Yes, we’re looking intently at you.

DR TREGENZA: Okay. I think also just to kind of comment that we would obviously be able to make comments on probably most things in the report, so I tried to choose some of the most pertinent points. I guess our main issue was about supporting people at

increased risk and a few things have come up over the last few years, particularly around the need for increased services for people with developmental difficulties.

These are people who have an existing intellectual disability and probably are cared for by services such as NDIS but often people do present with mental health difficulties as well. They are exactly the sort of case referred to where there's the sort of gaps in the system between the disability sector, which is sort of NDIS supported, and the public mental health service.

At present there's only one half-time psychiatrist who treats children and adolescents with these conditions sort of funded through the Women's and Children's. The adult position has funding but this has actually been vacant and the service has been unable to find a psychiatrist to sit in that role. I guess we continually advocate around these issues and we have meetings with the Minister for Health and Wellbeing twice a year. That's not on the agenda but we are very concerned about this particular group of people.

Another area we think there are quite significant shortfalls in the system is around forensic mental health and that's in a couple of areas. If prisoners have mental health difficulties and those aren't at the level that they're actually cared for by the mental health service such as James Nash House, then at present there isn't actually an in-reach service to the prison. So those prisoners are managed by the GP, and they can get support by contacting the forensic mental health services, but there isn't funding to actually support an in-reach clinic where a forensic psychiatrist and mental health workers, that specialist interest - - -

MS ABRAMSON: Could I - - -

DR TREGENZA: - - - provide a service.

MS ABRAMSON: - - - just ask you about that if you don't mind me interrupting. Different states have different models for forensic care. So is it that the Department of Corrections theoretically is supposed to be responsible for that person's care in prison?

DR TREGENZA: I believe that's the case, yes.

MS ABRAMSON: I am not saying it is delivered, just the model.

DR TREGENZA: No. And I also think that kind of highlights again the problem of different departments providing care, because mental health care is the health and wellbeing and funding comes from Corrections.

MS ABRAMSON: Corrections. Yes.

DR TREGENZA: So there has been a budget where this has been allocated more funding, but that hasn't actually kind of come to fruition at this time. We do have specialised services for young people under 18 in correction facilities, and in that

particular service there is a visiting psychiatrist and a mental health team that supports these young people.

The other area is around after prisoners are discharged or even people who have been in services such as James Nash House, which is a prison hospital, there needs to be more support, further community mental health teams to have some specialised forensic input, because the forensic psychiatrists work under forensic mental health in a sort of siloed area.

MS ABRAMSON: Yes.

DR TREGENZA: But a number of people who have perhaps committed quite serious crimes in relation to their mental illness are then eventually referred just to the community mental health team for follow up, and there is feedback that some of the psychiatrists and mental health workers don't feel that they are specialised enough in those particular forensic issues.

Perinatal mental health was another area that I think was worth mentioning as there's a strong push for the government having universal screening around perinatal mental illness and awareness that pregnancy around the time of delivery are risk times for women's mental health, and obviously the impact this has on the developing of the infant. The problem at the moment is the recommendation seems to be (indistinct) around increasing screening provision, but of course once people are screened there's going to be increased numbers of people who have concerns, and there's no - as far as we could see there's no actual funding allocated to increase the services provided through perinatal mental health.

So we think there is a shortfall in psychiatrists that work in this area, and the psychiatrists that do work in the area are under a lot of demand; not just psychiatrists but the mental health teams. So we would like to I guess see the Commission go further to make a recommendation about actually more service provision, not just screening.

Just briefly I just wanted to touch on substitute disorders as well, because again that's a very significant gap in the service between who provides support for people with substitute disorders who also have co-existing mental health difficulties. We know that people with mental illness often use substances either as a way of I guess self-medicating the illness, or it's an opportunity to feel somewhat better or more alive, and often these people do fit that fall between the gap between the substance use type service perhaps thinking the mental health difficulties are too severe to be able to fully support that person, and the public mental health system often will say they can't be of assistance because of the substance use difficulties, and I think that's been highlighted probably I am sure by other people.

Just a comment around improving emergency mental health experience. As you would probably know it has been a major issue in South Australia around issues such as ramping and wait times for patients, particularly psychiatric patients, and we think this needs a major overhaul. I think there needs to be consideration to actually thinking about the

physical environment in emergency departments, because we know they are incredibly busy, noisy and intense spaces, and I think an idea around creating specific spaces for mental health patients would be very helpful.

MS ABRAMSON: And we have got something in our - we've got a recommendation around that.

DR TREGENZA: Yes. Just we also do get feedback from our members. So psychiatrists that go to do reviews in the emergency department say of course that that environment actually worsens the condition that the person presents with, and I think also already there's some good ideas that have been proposed by the South Australian Government in the mental health services plan around creating alternatives to coming to the emergency department, such as urgent mental health care centres and a safe - - -

MS ABRAMSON: We have got something, I am sure you're familiar with it, St Vincent's Hospital in Melbourne which is a really - they've got like a café that's associated and other services so people don't have to go into emergency.

DR TREGENZA: Which are great ideas, and I think it's concerning that that hasn't happened here for many, many years. There used to be a service through public mental health that was a specific team called the AACIs team, it was assessment and crisis intervention, and that was also emergency avoidance in that people could refer an someone could go out and do an urgent home visit. That service got absorbed by general mental health and hasn't really been replaced.

MS ABRAMSON: This is one of the depressing things if I may say so about our inquiry. There are often these really good initiatives. So many witnesses have come to us and said, you know, that worked really well but it's been defunded.

DR TREGENZA: I know, and I do - I think particularly when Leanne was speaking, I mean one of the thoughts that came to my mind is that I think everyone's aware mental health services need increased funding, because I think people who work in them also know they are stretched to capacity, and I think that's why some of those difficult decisions are made.

PROF KING: Can I - I was going to wait until further - there's two elements there. So a number of areas you've said there's a shortfall of services, so child and adolescent, perinatal psychiatric, and so one issue there is obviously funding, but the other issue is the actual people, clinicians on the ground, and we could double fund psychiatric services tomorrow, but that's not going to create one more psychiatrist.

MS ABRAMSON: Not for seven years or longer.

PROF KING: It's not clear it would create any more psychiatrists, because my understanding is unlike some other medical specialisations where there is more people trying to get in to the specialisation my understanding is psychiatry is perhaps not one of

the ones that people are knocking down the door to get into. So it's not even - my understanding is it's not necessarily a matter of we just need more places in psychiatry. So correct me if I'm wrong, because you're looking at my quizzically. So how do we increase the number of psychiatrists?

DR TREGENZA: Yes, I think that's a really good point, and in fact we had some notes on - I mean I used to be a director of training for child and adolescent psychiatry, and in that area in particular there's only three to four funded spots sort of over a two year period. So we really are not training sufficient numbers of child and adolescent psychiatrists, and we also train in perinatal mental health as well. I think there are more applicants than positions. So for South Australian psychiatry training there's always a greater number of people who apply and our numbers are limited by the availability of funded training positions, and there's a couple of areas that are major shortfalls. So child and adolescent; the budget at the Women's and Children's hasn't been increased at all for psychiatry numbers or training positions, despite advocacy by my own department as well as by the college, and consultation liaison psychiatry which is psychiatrists seeing people who are part of the general hospital system, so perhaps admitted with a medical problem, but they've got whole existing psychiatric illness, or they are presenting after an overdose. So both those areas only have limited training registrar positions, and that actually caps our numbers of people who are able to apply.

So I think in South Australia there would be a great push to say we do need more trained and training positions, but they do need to be funded, and part of the problem is that they do need to be funded by the public mental health system to enable the training experience that's necessary.

MS ABRAMSON: Well, it's interesting because we do - I am sure we have got some, a commentary around that, around the need for more funded places for the trainees, because that's certainly - the public system. But the other thing I think - I don't know that we made a recommendation - was around the role of the private system, whether it could also be able to provide - perhaps not in some of the areas, but in other areas whether they could have places.

DR TREGENZA: We've actually had a project in South Australia in the last few years where we explored that, and funding was given through the training committee to sort of try and progress training for the private sector, and in the end it was disbanded, which has also happened previously maybe 20, 30 years ago, and it just seems to be a very difficult space to provide training opportunities, because patients are referred to see a particular psychiatrist. Most of the time GPs who have done the referral and patients who are waiting to be seen do want to be seen by the psychiatrist and aren't so happy to be seen by the trainee.

MS ABRAMSON: And I guess in the private system perhaps even more so because they're making the choice to go to that, they're not at emergency at the hospital - - -

DR TREGENZA: Well, exactly, and it's not really an issue in the public system in that we know all training psychiatrists are supervised, and the same - - -

MS ABRAMSON: Yes, I understand.

DR TREGENZA: But it's been incredibly difficult. It's also a bit difficult around practical issues such as, you know, medico-legal sort of insurance to cover - - -

MS ABRAMSON: Yes, I understand.

DR TREGENZA: So it hasn't been a successful year, but I believe there's been training positions interstate that have been able to offer that.

MS ABRAMSON: If you don't mind taking that on notice and just dropping us an email about that, that would be really helpful.

DR TREGENZA: We absolutely will follow up, yes.

MS ABRAMSON: Thank you.

DR TREGENZA: I don't want to take too long, I just if I can just make a comment around the consultations by video conference, because we've had quite a lot of feedback about the proposal for reducing the funding for MBS item 288, which is for a telehealth consultation there's additional funding to support the fact it's occurred. I think the general feeling is that if this was to occur I think there will be a disruption of services. So a lot of psychiatrists who do telemedicine or tele-psychiatry consults bulk bill those services because they are getting the extra funding, and often it's easier than trying to chase bills from people who are rural and remote and a long way away, and I think if people no longer are able to bulk bill they will stop that working service. So I think that financial amenity did benefit the patient, but also I guess make the process easier for the doctor. Am I running out of time?

Just one issue that's been another problem specifically in South Australia is the provision of 291s which are one of psychiatric consultations where the psychiatrist provides an assessment and management plan to the GP. There was a service through private health network that helped organise this, and so they took the referrals and then found the psychiatrist. We understand that's been disbanded earlier this year, and I'm not sure, I haven't had the information yet about that. However it didn't work very well, because a lot of the time people would be referred and then when the psychiatrist had (indistinct) often there was a (indistinct). This did prove quite difficult, so just to make that comment. That model hasn't worked very well in South Australia.

MS ABRAMSON: Is that covered in your submission?

DR TREGENZA: I think so, yes. Just briefly we've got a particular shortage with areas such as people willing to treat adult ADHD, specifically in our state, and I mean one thing

if tele-psychiatry could provide those numbers like the 291 or there was an incentive for people seeing patients with these disorders I think - I mean the interstate service may be able to actually sort of help fill those gaps. Having said that there's often gaps that people are required to pay as well as the MBS funded proportion. So I still think there needs to be consideration of the public mental health service providing treatment for that particular disorder.

MS ABRAMSON: Thank you. Thank you very much.

DR TREGENZA: That's okay.

MS ABRAMSON: No, that was fantastic. Thanks. Now, we have to take one person before the other one.

PROF KING: I think next Pat Sutton.

MS ABRAMSON: Yes.

MS SUTTON: I just need to pour my water first, I'm extremely nervous, especially after hearing Leanne's presentation, because she makes - strikes it home to me how important it is that carers - - -

PROF KING: Sorry, just before you start there, Pat, if you're able to state your name, if you're representing an organisation what it is.

MS ABRAMSON: That's because we know Pat already, so she's comfortable.

MS SUTTON: I was privileged to be here yesterday too.

PROF KING: But it needs to be on the transcript.

MS SUTTON: Sorry. Pat Sutton - I'm actually retired. I still do lots of advocacy work in the mental health sector, but I'm speaking on behalf of people with - very specifically people with severe mental illness. They are often referred to as those without a voice. I prefer to call them the preferably unheard, or even deliberately silenced, and that's how I see it. I have two sons who have never been asked their opinion in 28 years, and I know many others in the same situation, and there's lots of reasons, fear of retribution, fear of discrimination, et cetera.

There is so much spoken about consultations, and I believe that there's an awful lot of tokenism involved in this, especially in South Australia, in my view. One example is a few years ago the consumers and carers in the western region put together a petition of several hundred consumers and carers fighting against the closure of two intermediate care centres that was planned for (indistinct) in South Australia and it was a step up step down. Two of them, we've only got two of them now, and of course there's no way you

can use them as a step up, they're only step down now and very restricted populations use them.

I have been a carer and a consumer advocate for 29 years, and I've been working as a carer consultant in the mental health system since 1999 when I gave up my job in admin and decided to work in the sector. I've worked at local, state and national level, including non-consumer and carer advisory groups, and so I've kept wide networks, I maintain wide networks of consumers and carers across Australia, so I don't only speak from my own lived experience, I do bring other experiences too. I also had 12 years on the Guardianship Board as a community member, and this restricted practice is one of my priorities, and (indistinct) about people services.

I have heard many ministers bemoan mental health as the bottomless pit of funding. My belief is that because funding goes - and we did discuss this yesterday a little bit - funding goes into the hospitals. I absolutely believe that this cohort of the population, we need to move away from crisis driven hospital-based services and increase community services so that people can be kept well at home and in the community. There needs to be incentives for community services to keep people well, rather than the current incentives that are given to hospitals, and to avoid those lengthy queues in emergency departments which have been referred to.

Suicide prevention in my view only focuses on people with anxiety and depression, most of the anti-stigma campaigns, who do require therapy and talking, whereas a large proportion of people with schizophrenia for instance, and we're talking 10 to 15 per cent of people with schizophrenia, don't require the talk and therapy. What they require is the three things that are seen as the basics in life that everyone wants and needs; a home, a job and a friend, and many of them do not have that. What they suffer from is not depression, it's something I am told by a psychiatrist is called existential despair.

I think it's absolutely vital that people who provide services and support to people with severe mental illness, particularly those with psychosocial disabilities have time to gain trust, to build a rapport and have empathy and a caring approach. The system needs to work towards employing more of people with those characteristics in my view. The barriers which should be used to be driving services instead in my view are used as an excuse for substandard care and I think we heard that from Leanne. Lack of insight and ability to articulate goals, lack of confidence, lack of self-esteem all in the name of recovery apparently.

An oft repeated phrase that families hear is it is their choice. Perhaps they like to live in squalor, perhaps they like to eat unhealthy foods. Perhaps they like to be isolated in the community. It's not least restricted practice to avoid assertive services for some population, particularly when this leads, and it's been demonstrated that it leads to the person avoiding detention and hospital, and I saw that so much in my 12 years on the Guardianship Board. I do not believe people want to live in substandard residential facilities or with overburdened and aging family members, but of course at least they are

safe, and certainly in South Australia there's no - there's no alternative for many of those people.

The lack of supported accommodation, and again particularly in South Australia, is an absolutely unacceptable state of affairs in our country. Other countries, particularly in Nordic countries, have really good examples which work, and our cheaper than the revolving hospital doors - hospital syndrome, which is still maintained by many people.

My sons, Peter and Ben, depended on my husband and I for 28 years for all of their daily support. Peter spent many, many years in hospital. The first ten years of his illness one admission was actually two years in a closed ward, and that was only one of them. This is very expensive to the community. Now they live in a house which is divided into two flats, which the family purchased for them. They receive 14 hours shared support every day. So if the very successful core and cluster type housing, which people in South Australia seem to avoid, was utilised where we have six people living in separate flats my sons 14 hours can be divided into seven hours each. So if we had six flats you'd be divided into four hours each of funding. I mean if you can - I can't understand why people can't see that. There's an economic gain in that kind of housing for people who would benefit from it.

I have to say that the NDIS has transformed the lives of my two sons and also the rest of the family. However, this was due to very, very strong advocacy by my family. Many others are not receiving the support that my sons are, which is why I'm not really retired. They're not getting the help they need from the government or the non-government agencies to understand the new language of the NDIS; that is it's about impairment caused by the mental illness, it's not by the symptoms of the mental illness, and that's still being repeated by a lot of people.

The mental health non-government agencies are even struggling themselves with this I understand, and they have tended to resist the NDIS over the years, which I've been very frustrated with, but this is because their own organisations have been put at risk. In my view the mental health peak bodies do not represent consumers and carers, they represent their own organisations, rather than speaking on behalf of consumers and carers.

People with schizophrenia have significantly reduced lives, less than 50. My son is now 49 and this is a concern to me. This is due to physical health issues. They don't die because they have a mental illness, they die because they don't receive timely services and supports for the physical health issues they endure, and often caused by the antipsychotic medications that they take; diabetes, heart attack, cancer. Ninety per cent of people with schizophrenia smoke because they see it as an activity, because they're not engaged in new activities because they don't get enough support.

There is a significant lack of GPs, and to me is the significant contributor to long waiting queues in the emergency departments. This is particularly the case regarding GPs willing to take on people in this cohort of the population. My sons recently were cared for by a GP from an agency called Adelaide Disability Medical Services, but the Federal

Government defunded it. The GP used to come to my sons' home every six weeks or so and spend at least an hour, because my sons come and go, they won't just sit and listen to someone, but she succeeded in engaging with them where no one else had, and I believe she has certainly helped them to avoid hospital, especially one of them during that time.

One of my sons has got diabetes and an eating disorder and he's a vegan, which is almost as bad as the other two things, and the other son has chronic venous disease in both his legs. There needs to be a system other than the fee for service, which is what the Adelaide Disability Medical Services had, and I don't understand why it was defunded. It's so vital for people with disabilities.

Currently a new agency, a new non-government agency supports my sons. So after 28 years of waiting this started last April. The achievements they've made are incredible. They send photographs. I have one of my son's doing yoga, the other one goes fishing just about every day.

MS ABRAMSON: Not the vegan son presumably.

MS SUTTON: No. He won't even let them kill flies in his house. He made - the other day he made them suck ants out of his house with a vacuum cleaner and let them out outside. He has a strong respect for life in every form. They go for long beach walks. They have a lead worker. There's six workers all together manage those 14 shifts a week. He manages all the multiple medical appointments my sons have with specialists and psychiatrists, and he actually gets them to go to some appointments, which is something we struggled with for many, many years. These sound like basic things, but we've been without that support for 28 years. They were extremely isolated and dependent on us completely as I say, despite my strong advocacy in the sector.

The secret of these support workers is empathy, a caring attitude, spending time with my sons. Not academic qualifications, they actually - most of them don't have academic qualifications. Keith and I, my husband and I now have serious health issues ourselves. We're both now in our 70s and our support is absolutely unsustainable. So it's been quite timely in a way. So after 28 years of frustration, despair, grit, my motto has been don't get too excited. I know Leanne's story is not unique and I do believe that at least one of my sons would not have survived without our advocacy and support.

I think that what was needed in Leanne's case and in my sons case and most other people who have got severe mental illness is that coordinator we talked about so much now. Someone who's accountable for speaking to everybody involved, including the family, because family will often - and that's got to be assessed I understand too - might give a more realistic situation, because it's often quite different to what the person themselves may say. My sons will say they don't have a mental illness, they don't have diabetes, we don't need support, and yet they have accepted extremely well that 14 hours of support a day, but it's because of the attitude of the workers.

PROF KING: And the individual.

MS SUTTON: They don't go away. My sons know it's not going to go away. They know it's going to be there, and so they have to accept it, and so they learn to accept it. My son - one of my sons doesn't talk at all, he writes notes to them saying how much he appreciates their care, even though sometimes he tells them to 'f off'. I shouldn't finish on that line, should I. So I'm hopeful and I hope that a lot more people in my sons situation, and I know they're out there, become participants of the NDIS and also have a successful story as ours has been.

PROF KING: Thank you, Pat.

MS ABRAMSON: Thank you, and also thank you for assisting us yesterday.

PROF KING: Can I just - it's really a comment more than a question, but I think your comment about what is needed often isn't the qualification, it's the empathy.

MS SUTTON: Absolutely.

PROF KING: I'm not sure how they teach that.

MS SUTTON: I know that. I mean I've had to actually discontinue services of three agencies in the care of my sons over the last three years.

PROF KING: That time with the NDIS or - - -

MS SUTTON: No, the NDIS only started in April last year, but it was at that time when an agency which had been support to my son, with not so many hours of it, it was lesser hours, just seemed to not understand that we now have choice and control, this is what we need, but we had to fit into their policies of what they thought, just to make a long story short, and it was not suitable for my sons, and against my wishes, because I really respected this organisation, it's one of the larger ones, and I wanted them to continue, it just wasn't going to work. They wanted to do - they wanted to split the work for my sons into different workers. So you'd have all these different workers coming into their house, and they had restrictions on the kind of work they could do. They couldn't supervise my son's diabetes because it didn't fit with their policies and practices, despite the fact that they have agreed to do that previously.

So there were just things that just weren't going to work, and luckily I found this organisation which is newly developed, it's only been around for about two years. It is mostly people from India with Indian backgrounds, so I do think that they do have a very caring approach perhaps. I don't know whether it's because they're people from India, but they're all - all the six workers are just fantastic. For instance there was two of them, two women in the very beginning I could tell did not have a lot of confidence and they were a little bit worried about whether Peter would respond to them and whether they would be able to engage well, and now - in April they started and now they're fantastic, they're two of the best workers, and it's just because they persisted and they learned to pull away.

I think it's been useful because Peter and Ben live in - one lives in the flat upstairs and one down, and if Peter's telling them to go away and any particular time they'll go downstairs and talk to Benny. They say invariably when they see Peter again that he's fine again. So it's just learning, spending the time, and this is why it's so important for people to have time. I mean I do believe that Leanne's brother - there was no one who was spending time with him to work out what was really going on with him. I can't believe that there was, otherwise they would have learnt - maybe not what was going to happen, but certainly what was needed, and to say that a person that she's described that their goal is to find employment I find crazy. You know, one of my sons says that too, and he's got it in his goals, but first and foremost in his goals is that he needs the support to live independently in the community and to engage meaningfully in the community.

MS ABRAMSON: Thank you.

PROF KING: Thank you, Pat.

MS ABRAMSON: Thank you very much.

MS SUTTON: Thank you.

PROF KING: Next we have Danielle Malone. No, we don't, sorry. We are having lunch then, my apologies. That will teach me to look at my phone. Thank you, my apologies. We will break for lunch now. If we can break for - what are we looking at in terms of time. So if we can be back by 1 o'clock. Is that okay? Back at 1, an executive decision.

LUNCHEON ADJOURNMENT

[12.23 pm]

RESUMED

[1.03 pm]

PROF KING: All right. Okay, let's get started again. Next if we can invite Danielle Malone.

MS ABRAMSON: Can we apologise for us eating.

PROF KING: Apologies for us still eating. Danielle, if you're able to just state for the transcript your name, any organisation you represent.

MS MALONE: Sure. Okay, so thank you for the opportunity. My name is Danielle Malone and I'm presenting an individual submission today, not representing any affiliations mentioned herein. Thirty years of experience in public education as a teacher and ten years in educational wellbeing as a school counsellor and wellbeing leader for students aged between 5 and 18 years has provided an insight into opportunities this inquiry presents. Additional experience with chronically disengaged youth from 15 to 25

years of age with an MDO has equipped me to speak about transitions into adult life for young people with mental health barriers.

Firstly I would like to highly commend and concur with your reform objective of better use of childhood services to identify and enable early intervention for social and emotional developmental risks. Early intervention and prevention recommendation 17 of the draft report acknowledged many necessary actions. However, without accountability the measures will have minimal impact as they are effectively in place already, but resourced and utilised in (indistinct).

I strongly believe that the effective whole population mental health prevention and intervention will only occur through enforced wellbeing standards at preschool, primary and secondary levels of education. With standardised screening and compulsory intervention life outcomes and productivity for individuals and hence the wider community could expand exponentially.

Young people are highly susceptible to mental illness and that's the issue (indistinct) notes, many mental illnesses commence at school age. After listening to submissions from child psychiatrist Dr Goodfellow and Professor Paul I now understand that mental health conditions can also present in infancy. Children and families are legally obliged to interact with education facilities, public or private, and as such teachers have unique relationships with students that cannot be replicated.

As with many industries human resource accountability is key and time is poor. This is especially the case with early childhood educators, primary and secondary teachers, with student complexities presenting increasing difficulties. The enforcement of NAPLAN within schools has diminished the focus on wellbeing within the department and therefore in schools. South Australia has highly commendable systems, processes and personnel. All that is needed is the benchmarking to ensure social and emotional learning preventions and early intervention is undertaken as part of school compliance processes.

A plethora of evidence indicates the benefits to learning of improved wellbeing, yet this is not emphasised in education departments. Should there be an enforced standardisation of wellbeing reporting and intervention attention and resourcing (indistinct) does not equally into wellbeing.

Stigma is an issue that has underlined a great deal of intervention at individual and systemic levels, and is a question that has been asked repeatedly in the public hearings that I have viewed. The use of specialist services is minimised by parental and possibly workforce fear of stigma. Like the infant mental health referral disconnect that Professor Ball spoke of school age referrals are significant disconnect also. In the South Australian Department of Education annual reports on behavioural incidences the number of individuals exhibiting repeated behavioural incidences is considerably higher than those referred to the specialist support services. All support service referrals require parent consent, and many parents fear the stigma of a label disability, be it physical, cognitive, social or emotional.

In order to rid this stigma in early prevention and intervention I believe the hierarchical taxonomy of psychopathology (indistinct) model of risk identification and targeted intervention would prove highly (indistinct). This model uses trans diagnostic spectra beginning with the internalising or externalising as a first stage of general psychopathology, and fear or distress and substance use or antisocial as the next stages.

For (indistinct) taking a masters in global public health with preventative mental health being focused I have discovered research from a number of scholars using this model for early intervention. Forbes, Rappaport and Kruger present a stepped intervention using this model in their paper titled 'Opportunities for the prevention of mental disorders by reducing psychopathology in early childhood.' This was published in the Elsevier Behaviour Research and Therapy Journal 119, and I have a copy here for anybody that's interested, and there's also a digital copy on there.

PROF KING: Yes.

MS MALONE: In regards to recommendations in the paper I will make notes in response to the points that I have not addressed at this stage. So recommendation 17.2, 'Social and emotional development for preschool children.' The Australian early development census has been effectively collecting this data about 5 year olds since 2009. This is a very well managed and implemented process and could easily be expanded to a younger age group.

17.3: 'Social and emotional learning programs in the education system.' The national curriculum includes social and emotional learning in the health area. There are many other programs to support this area, including a Shine program and the Keep Safe Child Protection program in South Australia. There's similar interstate, and these programs do not have accountability (indistinct).

17.4: 'Educational support for children with mental illness.' It is in place in South Australia using the effective model of preventative and developmental wellbeing, but highly under-resourced for the demands within the role. Referral pathways are used, but waiting times are prohibited, face to face access severely limited, and apportion funding allocations and (indistinct) number of sessions (indistinct) inadequate.

The South Australian Department for Education has an excellent program of reengagement with students at risk, of which those with mental illness are high in number. This is called flexible learning enrolment, and I believe Uniting SA have a submission that may provide that service as well. Mission Australia have a report, a research report on the results of their low enrolled students. That's one evidence of what's being achieved in that. The funding model for this is prohibitive because it comes from the school. So in a small school you're losing the funding of that student, which if you're trying to integrate school - them back into school it is very cost prohibitive, but it combines education and health and social services departments. It is known as the 'I can flow model', and having worked at re-engaging students I have personally witnessed

immense improvement from high levels of self-harm (indistinct) behaviours to full engagement with education and training. It was fantastic.

So working with the local or MDO these at risk students reported feeling highly isolated and incompetent and when brought together to engage in meaningful activities and dialogue they begin to make positive changes. One of the best initiatives experience within those role is an art therapy program. Australia is highly dominated by sport and athletic pastimes, and that is even more accentuated in the country. A significant portion of disengaged students prefer creative pursuits such as music and arts. The sense of belonging, method of expression and sense of one's worth emerging from this program was significant.

The success of this program was assisted by my personal appreciation for the arts and my own experience of isolation, lack of creative expression and child abuse related depression. My passion for engaging rural minority groups into productive activity was born from my own circumstance and compassion (indistinct) to see great results such as social anxiety and an early school leaver to an international university exchange student where (indistinct) a degree. It's just so rewarding to see the before and after (indistinct words). When the Federal (indistinct) engaged funding ceased in 2004 I returned to educational settings as (indistinct words). That would be 2014, not 2004.

17.5: 'Wellbeing leaders in schools.' Most schools in South Australia have a wellbeing coordinator student counsellor to undertake preventative model of wellbeing alongside the intervention approach. I believe that's not the case in other states.

PROF KING: The difference between states.

MS MALONE: Yes. So although I hold a diploma of counselling in South Australia a school counsellor does not need to have formal qualifications other than an education. The role includes a teaching portion for most small schools, which is problematic. I am a member of a local secondary wellbeing coordinators network and there are many responsibilities included within wellbeing role in most sites. Redefining this role would be a significant benefit.

If the preventative model was held accountable requirements at the crisis intervention stage would be reduced. According to the Australian Bureau of Statistics 2017 suicide is the leading cause of death among 5 to 17 year olds, although largely concentrated on 15 to 17 years of age. Should the compulsory intervention be implemented the demand for crisis intervention and (indistinct) would be significantly impacted.

17.6: Wellbeing data has been collected for schools across Australia, particularly at the commencement of schooling in the Australian early development index, and where disengagement levels increase dramatically the middle years of schooling. There's a lot of evidence to show the disengagement process starting from the beginning to the end of middle years. This data has been extensive, but does not appear to have been used to inform practice and therefore benefit population growth. I will just add in there that since

NAPLAN has been compulsory Australia's results in the (indistinct) 15 year old world data collection have declined steadily.

There are so many fantastic initiatives already in existence. There's so many wonderful workers within education that have so much to give. There are so many workers in health, in NGOs that I've come across with my work, so many of you wonderful volunteers, personal people willing to give their time passionately, but our systems don't allow for a positive change. I don't think our systems need to be reinvented. We've had so much - we already have assessment processes, we have programs. They are all there, and they have been researched for evidence. So it's all there.

Positive Schools Network is a great resource of professionals, but also an indicator that change requires boundaries of enforcement rather than encouragement as their progress is voluntary for sites and that cohort is dominated by private schools. In the report there was a question, you know, what should the funding be. So private schools are already voluntarily working on wellbeing improvement and the results are phenomenal; really, really good. If that was a compulsory component for schools because there's benchmarking we would see fantastic results.

I truly hope that a renewed focus on wellbeing within education emerges from the inquiry. I would like to express my gratitude to the Productivity Commission for ensuring the process of public hearing is afforded to people like myself. The opportunity to be heard and valued as a professional with experience working with young people, and as an individual with long term lived experience with mental illness. Thank you.

PROF KING: Thank you. Could I ask a couple of questions. It really goes to what I take is one of the key points that we've raised here and made a number of points, but the benchmarking point. I wonder if we've been, from the Commission's perspective we've been approaching the issue or parts of the issues of school from the wrong direction. So we've talked to many principals, many people working for them who say exactly what you say, which is there are great programs out there, but we don't know which ones, there's so many, and when it comes time to choose it's usually principal of next school, what have you got, (indistinct), and go, okay, let's put that one in place and there's no uniformity.

So I guess our approach has been to say, well at a high level evaluate and try and create that uniformity, but I wonder if an implication of what you've said, if you bring in the benchmark, the social and emotional welfare type of benchmarking at the schools, if you change the incentives at that school level do you then need the consistency or consistency to come out of the school saying, gosh, we're down in the bottom third of the list, we've got to do something.

MS MALONE: There doesn't need to be consistency because each (indistinct) or each school have different needs. So you're not - one program isn't going to suit every school, and being from a rural school and by also working in (indistinct) schools, part of my work is in Port Pirie which is quite a different population, so schools are categorised as far as

social and economic disadvantage. So the funding model is based on that, and so - yes, very, very different cohort depending on staffing, student numbers. So in a large school the school counsellor that is their role. Within my role I was doing cultural confidence with monitoring the Aboriginal individual learning plans, guardian of the minister, case managing them, students with disabilities, managing them, student voice, so SIC engagement, performing arts, you know, facility management. So there's - and I taught seven different subjects over five years. So that just shows you - you know, like the systems are good, but in a small school that can't work.

PROF KING: Yes, and being a jack of all trades.

MS MALONE: Yes, which is great opportunity. I now can teach all sorts of things. I've learnt lots of (indistinct) things, but the students are disadvantaged by not having specialist teachers, and so we see an exodus away from rural schools to ordinary schools - well, it's the larger schools. But back to the question about programs, I don't think we need uniformity, we just need compulsion to benchmarking. Yes.

PROF KING: So compulsion to benchmarking, is the benchmarking transparency of the outcome, is that going to be enough or we end up with what I suspect has happened with NAPLAN, and apologies because I am guessing, but I suspect what's happened with NAPLAN, and I will just talk Melbourne because that's the area, there will be a number of schools, particularly in middle class and upper middle class suburbs who, yes, the NAPLAN results drive an awful lot of things, because they would be very worried about the benchmarking. I get a little bit worried, but perhaps in less well off areas, that the parents aren't as engaged with things like NAPLAN results and so the pressure goes off the school to perform. So I worry would the same happen with benchmarking, that it would be a great tool for the upper middle class and middle class areas, it would be a great tool for some regional areas, but - I'm trying to think, and apologies if I've got it wrong, but I'm thinking of Elizabeth as being equivalent to say Dandenong in Melbourne, an area which has had a lot of employment, a lot of factories closing down, and so on. Would you get the same engagement there or would it just be, yes, the benchmarking on social and emotional wellbeing, no one pays attention to that?

MS MALONE: I think - we already have the data collection as I said. That data is not acted on. So what I'm saying is - and that data is collected in all schools in South Australia. I believe there is - well, there used to be a middle years index in eastern states. I'm not sure what's happening there any more. For a while it was national, nationally, but an offshoot, they keep changing the way they collect it, the age group. So for example in South Australia it was (indistinct) years 6, 7, 8, 9, middle years. They then introduced years 4 and 5 and that became a large portion. So the changes from what's been done the results are just skewed. So the data collection is in itself not a bad - like it's a big process, but the way that it - - -

PROF KING: Nothing's done with the data, how it's - - -

MS MALONE: It's not a good research of skills, yes. The difference between the sites is not as much of a problem, because they are all following the same Education Department policy, but it doesn't matter if it's Brighton High School down here, which is a high social economic area, or whether it's Port Pirie which is a low social - - -

PROF KING: Yes.

MS MALONE: It doesn't matter which school, they are still following the same accountability measures which is NAPLAN, fact testing and (indistinct) results. They are the key outcomes, and that's why wellbeing has dropped off, because it's not an outcome, it's not - - -

PROF KING: Not (indistinct words).

MS MALONE: Yes.

PROF KING: Thank you.

MS ABRAMSON: I just - thank you for that - had one question. In our model we have really focused on the school being a gateway, so that it's actually the students would be directed to services outside the school as opposed to a model of psychologists or counsellors in schools. What's your experience been of your local health networks and the PHNs, et cetera, and the ability to connect with schools when you need help and services? And it's fine if it's not good, that's why we're asking the question.

MS MALONE: Having worked both - both worked within school and out of school I feel like I'm well equipped to answer. So a lot of health professionals get very frustrated when they're trying to communicate with schools. Schools are - like most school work educators are face to face with students most of the time, or they are on yard duty, or they are dealing with a problem, or they are - so they are not contactable very easily, but that's just a different understanding of industries. I would say our system again is quite good, our referral system is quite good. I don't think we need a psychologist in our school. I think your concept of wellbeing coordinators in schools is excellent. That's what we have here and I think it's a great model, because the coordinators are in charge of the preventative and developmental model; perfect.

MS ABRAMSON: And we didn't want them to have to have their teaching duties as well. We saw that, we understood that.

MS MALONE: Yes. But the other things that are put onto that coordinator needs to be limited so that they can make sure they are (indistinct) those preventative programs. The referral process to psychology is great, but within public schools the specialist services that are free is limited.

MS ABRAMSON: Yes. So it's a service availability issue as well. Yes, I understand. Thank you.

MS MALONE: The referral system is fantastic, yes, other than needing the parent consent.

MS ABRAMSON: Thank you.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you very much.

PROF KING: Next we have Ellie Hodges.

MS ABRAMSON: Thank you.

PROF KING: Ellie, if you could just state for the transcript your name and if you're representing an organisation your organisation.

MS HODGES: I'm Ellie Hodges, I'm founder and executive director of the Lived Experience Leadership and Advocacy Network, also known as LELAN. We are a peak body for people with lived experience major health issues in South Australia. So I have a statement and answer some questions, hopefully done.

To provide context on LELAN we amplify the voice, influence and leadership of people with lived experience to drive change. We have three main areas of focus; developing the capability and influence of people with lived experience, nurturing organisational and (indistinct) capacity for partnering better with people of lived experience, and impacting system improvement agendas to benefit people with lived experience.

We work with the Mental Health Coalition in South Australia, who you will hear from next, the lived experience community and other organisations on submissions to the inquiry, and we (indistinct) those to provide a human rights (indistinct) to what we contributed. Today though I am here to (indistinct) the lives, perspective and wisdom of people with lived experience, in particular consumers, but note that we have carers involved within our organisation as well.

I want to acknowledge my privilege in being here before you and honour the people who have much to contribute and could say the same things that I do, but don't get listened to for various reasons. Even when I was most unwell I still had choices open to me that others don't and I could speak up because of my education, working within the health services for my whole career. So I just want to acknowledge those differences.

I know that many people waited eagerly for your draft report and it just so happened that I was in Victoria at VMIAC, which is the LELAN equivalent over there, a consumer conference when it was released. I will say that the feeling of the state and territory peaks that were present at that time, six in total, was they left us wanting more from the report

that is being described as a report of the generation. So we (indistinct) a lot of ways of what this could do and the potential, because there's been many, many as you know.

At that time we released a joint statement. We agreed that an urgent generational shift is required and believe that it's critically important to ensure the inclusion of consumers in decision making processes that directly affect their lives. We share concerns that there was no single statement to say that consumers will be an integral part of future directions. We know that the system is broken and we believe that it is not a matter of fixing the system so that it looks similar, we're talking about creating a system that meets the consumers' needs. We know this happens when consumers lead when we're given that opportunity.

I can let you know that the more of the report that I have read the less disappointed overall I am, yet I wish they went further. Whilst there is excellent analysis of the current issues, challenges and opportunities I feel that the solutions offered continue to be through a medicalised clinical lens that I and many others feel replicate these things in the future, and thus would not bring the generational shifts that we want and we desperately need.

There are three main areas that I'd like to discuss today relating to the lens, language or framing of recommendations in the final report regarding systemic advocacy as well as how lived experience is recognised, valued and utilised and may have some ideas for solution around that.

On lens, language and framing, and this is a quote from your report right at the start from the overview. 'Through the lens of participation and contribution this inquiry examines how people with or at risk of mental ill health can be enabled to reach their full potential in life, have purpose and meaning and contribute to the lives of others.' I wonder how different the recommendations would be if the report stated at the outset a different lens and focus of inquiry.

Through the lens of participation and contribution, which I will keep because you are the Productivity Commission and have a particular lens, but that (indistinct) is different and that it says, or was something akin to. This inquiry examines how people experience in distress or crisis and needing a bit of extra help, frequently from the ongoing effects of trauma or factors related to the social indeterminates of health, how they may be supported through a cover (indistinct) and live the lives of their choosing, and how that would shape the recommendations in a different way, if that was centred and forefront and underpin everything that came.

From the outset and (indistinct) deficit framing of our experience would not underpin every analysis or comment in a document. Mental ill health would not be the dominating descriptor and a continuing endorsement of hierarchies of power and vested interest would not persist. It would open the way for consideration of more humane and compassionate understanding of people and their experience, and importantly a greater focus on human rights and social justice. As a (indistinct) system that demonises,

criminalises, coerces and uses power over us, which at the same time tells us we are weak, have something wrong with us or are not doing enough for our country causes more harm than help for those of us accessing services the people who love us and for those that provide the opportunities and services that we engage with too.

On systemic advocacy, or consumer participation as you have labelled it in the draft report, thank you for putting this recommendation in the pulling together the reform section, and with governance and responsibilities. It's critically important that lived experience is recognised at that level. However I would like to highlight the (indistinct) that exists in current investment and practice in this area across Australia, and invite you to supercharge draft recommendation 22.3, enhancing consumer carer participation. Words and language are important, and I believe that in 2020, particularly from a document wanting to be the driver of generational change, we need to be positioning people with lived experience in greater roles and capacity than participate.

National safety and quality service standards speak of consumer engagement and accreditation of health services are linked to that and meeting audits, but that is not enough either. Since mental health reform became more visible in the early 1990s there has been a general statement in many documents and reports that people with lived experience should be involved in all levels of decision making. If we are true to this there are structures that support a multitude of ways to be involved, participate, engaged with would be visible, which they are not and particularly in South Australia. If practices were to have changed in those nearly 30 years now we would be talking about how clinician services in the mental health system partners with people with lived experience at a minimum, bare minimum partnership at each level.

Co-production would be core business and consumer led initiatives would be invested in and learned from. The inequity I speak of in this context is an assumption that all states and territories have a peak body for people with lived experience, and different states have consumer carer involvement and Victoria has both, so does the ACT.

Whilst LELAN currently exists as a peak body with funding this does not come from government and as of July 2021 we will be unfunded again unless something changes. Our first funded project of almost half a million dollars over two years has come from philanthropy, and it involved us asking a university to partner with us. We have good ideas, we do innovate and inspire. We are building up community in our collective voice. We will have impact, yet the South Australian Government does not resource or invest in people lived experience to be involved in systemic advocacy, and (indistinct) broader than LELAN there, just to be very clear.

The gap means that potential for active and meaningful non-tokenistic involvement of people with lived experience in strategic decisions, policy and governance is greatly lacking and maintains a status quo. A lot of talk of symbolic inclusion, yet no actual observable real change in how people with lived experience are provided the opportunity to hold the system and services to account. It is too great a burden for individuals to do

alone, and it makes the power imbalance between bureaucrats, decision makers and people with lived experience insurmountable.

Our value to the system, again not LELAN, all people lived experience, and the undefined dollar contribution that we add to reform efforts is not being realised in current structures and decisions, and this is replicated in other jurisdictions, including nationally. It's not just states and territories that miss out as - we can only engage on state matters, so who's there at Federal level around that. It's a small investment that we would need for this for great benefit. So the five years of funding you recommend would be very welcome, and it would ensure that lived experience and their involvement in systemic advocacy is more than a project, which it currently is, of even the National Mental Health Commission and other agencies looking into this work. A report put out by the National Safety and Quality Commission in 2018 around the attributes of person-centred care gives insights into the benefit of involving people. Experiences of care are improved. Workforce experience of wellbeing and morale improves, which has economic ramifications. There are better outcomes for health and mental health. Safety and quality is improved and there is better value of care because we actually put the right services in place earlier and that saves money overall.

Speaking to recognising value in utilising lived experience, it's also acknowledging that we – the benefit of lived experience around the table and being centred is we offer more than just an experience of so-called mental illness. We have other skills, experience and qualifications. The mental health system is complex, we hear that all the time. We live with complexity. We live with that discomfort. We survive that discomfort. It's how we navigate recovery and our life. We want to be part of the change. We will not run from the change that needs to be made or implementing it. We've been saying for too many years that we are here. We're ready. We want to lead it, as well. We may have vulnerabilities, but we also have immense strength and resources and we want involvement at all levels, where our expertise is not minimised, sympathised, patronised, tokenised, or co-opted. We know the statistics of the impact and experience of mental health issues – one in four, one in two, everyone, is what people go with - and increasingly, people are disclosing their lived experience in work roles, and we are seeing that that is being ticked off as having lived experience at the table. But when they are at the table in other professional roles, they are not centring or prioritising lived experience or making decisions from that frame, and right now, given the state of things, we need dedicated positions and opportunities. We need leadership from others to open the door and enable us this right that we have and to provide structures that keep it embedded and not based on personalities. That too often happens.

There's a politics to lived experience because of the injustice and the oppression that we've had to live with and get through, the harm of the system when we try and ask for help and we get tossed around. We have to double prove ourselves. I've sat at many tables and everyone else has a fancy title, a fancy suit and a big paycheck. It comes around to my introduction: "I'm Ellie and I'm the Lived Experience person", as if that is all I am. Another co-option happening right now is around co-design and coproduction. We need this as standard practice and what we have at the moment is a lot of words and

some goodwill – some of the time – but it is not happening. So thinking about what we could do beyond this, a couple of years ago I was – did some consultancy with the South Australian Mental Health Commission looking at how we strengthen pathways for lived experience voice, influence and leadership. I spoke to advocates, I spoke to commissions around the country and a couple of peak bodies, and these are some of the main headings of what was in the report derived at that time:

Structures beyond individual engagement are needed to effectively influence systems of practice. We can't rely on individuals. We need structural systemic advocacy embedded. Any structures decided upon must suit the unique context and circumstances of where they are being considered and for what purpose.

When the voice of lived experience is not embedded within systems, it can be easily lost or co-opted into the more dominant way of being. It's hard for peer workers to be in a team where clinicians lead, and there's eight. Power imbalance again, which I – pathways and structures should not be restricted to a sole focus on lived experience or low level roles. We need to live the - all levels. Structures and pathways must focus on building capacity and capability of people with lived experience and others.

Coproduction is appealing to many as a supportive structure for lived experience, voice and influence. It's still very much a work in progress. Pathways and structures need to create space for all people with lived experience. Not the privileged ones, not the white ones, not the educated ones, and not those with anxiety or depression. We need it for all people and all experiences. Lived experience leadership need to be addressed. Organisations have a responsibility, and the system has a responsibility, to ensure environments are conducive to lived experience voice and people with lived experience thriving in their space. If a workplace and a work culture makes being present there as a lived experience worker difficult, it's not because we have failed or are not strong enough, which is what we are currently told. It's actually the culture of the organisation and the system that is not safe for us as a workplace.

Structures set up solely for the inclusion and agenda of people with lived experience are an important part of the engagement and involvement landscape. A peak body or central organising entity for lived experience is the preferred option for strengthening the voice of lived experience by people with lived experience and others. Peak bodies more easily gain access to decision-making tables that are out of reach to individuals. There's a different accountability mechanism that can be inbuilt into the system by having organisations for systemic advocacy solely by, for and with people with lived experience. Peaks provide a pathway for collective voice that's harder to shut down. I feel like I should stop.

PROF KING: Just a point of (indistinct) – so the report you were referring to at the end is – do you have the full name of the report?

MS HODGES: It's Pathways to Strengthening Lived Experience, Voice and Influence in South Australia.

PROF KING: Okay, and that's available?

MS HODGES: No, but I have Lawson's email.

PROF KING: If you could email it through that would be fantastic.

MS ABRAMSON: Well, the irony – firstly, thank you for such an eloquent presentation. It was really very, very informative. Examples of where you think it's worked well – so where lived experience has been taken as a serious part of the coproduction or co-design, not – as you said, they go around the table and 'oh, you're the lived experience person'. So do you have some examples of governance where you think it's worked well?

MS HODGES: One example in South Australia, which was double-edged in some ways, is the Lived Experience Telephone Support Services. The design of that was coproduced, but then when it came to the funding of it, it changed, and there was some difficulty around that. So what we find sometimes here is that services may commit to a coproduction process, but then decision-making, they don't agree or then they don't fund it. Where it's been done well, I think it's not in government services. It's in – NGOs are doing it better, partnering and walking alongside people to engage them and talk to them about what would work, what would hope. It's when there's more lived experience staff on a workforce, where they can shape things and when they get into decision-making roles.

MS ABRAMSON: Although it's interesting, you made a good point, I thought - amongst a number of good points – about lived experience, that just because someone has lived experience, it doesn't mean that they bring it to the role that they're actually doing at the time. So it's actually got to be a combination of a person tapping into that experience in their day job, for want of a better word.

MS HODGES: Absolutely. If we look at Beyond Blue, Georgie Harmon is now out publically as having lived experience. I'm sure that when she's at the table, she's there as a CEO. She may have a more compassionate, understanding and accepting response, but she is not making decisions - - -

PROF KING: On that basis, yes.

MS HODGES: - - - from that place. We need it as well. It's not one or the other, it's both.

MS ABRAMSON: If you can – if there are any examples that come to mind in or after our hearing, just – if you could email Lawson, we'll have a look at them.

MS HODGES: And it's also not just coproduction but the lived experience (indistinct). So in Queensland, there is a service called Brook RED that provide housing and recovery and group support to people, which is a completely peer organisation.

MS ABRAMSON: That sounds excellent.

MS HODGES: So there are examples around country that we can learn from.

PROF KING: Are there – sorry, last question. Are there examples in the clinical space? Sorry, I know that's putting you on the spot.

MS HODGES: No, there are. I would want to think about that, yes.

PROF KING: If you're able to think about that and if you can shoot through an email, that would be fantastic because as I see it, it appears that the cultural gap is biggest in the clinical space and if we can get across that gap, that would be fantastic.

MS HODGES: And I think a complex figure around clinical as well is – so a lot of it was happening on the side, and then we got funding, so it's now my paid day job. But before that I was also a therapist, and our - about lived experience, so people would come to me specifically because I had that. And because of my speciality, which is my lived experience, my trauma and eating disorder, the Statewide Eating Disorder Service had very big questions about my ethics and concern.

I would suggest that my ethics, I had to think more about them and reflect more than most people as a practitioner about how we use lived experience. So there's stigma and discrimination that happens where clinicians don't feel same to come out, or how to use that in practice as well, because of judgment. I know multiple people within SA Health whose jobs have been made very difficult around this. So yes, I can certainly add some examples.

PROF KING: Thank you so much for that.

MS ABRAMSON: Thank you.

PROF KING: Next we've got Geoff Harris.

MR HARRIS: Did you say we've got tons of time?

PROF KING: No, it's just that we're running about 20 minutes late. We haven't started hitting the points yet where we say oh God, we need to stay overnight. If you're able to state your name and any organisation you represent for the Commission.

MR HARRIS: Yes, I'm Geoff Harris from Mental Health Coalition of South Australia, and we provided a submission post draft. So I'm presuming that you've seen that and have read it, so I won't be - - -

PROF KING: No, sorry.

MR HARRIS: And also I work with Ellie around the submission, a joint submission, particularly focused on human rights aspects from some consultations that we had.

So to kick off, to follow on from Ellie, I would say funding, lived experience, peak bodies is critical. It's critical to having capacity for lived experience voices to get organised. I think the history of inclusion of lived experience voices in Australia has been one of just kind of capturing that voice into processes where people can only hear a small amount of that voice and can't deal with the bigger issues that people are trying to bring to the table.

So I think that's one of the key things that can move us from that kind of consultation mode to one where people with lived experience have more resources to talk about issues and develop policy positions and avenues. So I think it's critical.

Also one of the questions you asked about lived experience in the workforce, I think some of the people following me could really talk to you a lot about that. But in the mental health coalition we've done a fair bit of work in the lived experience workforce in South Australia and a lot of it is looking at what are the roles, what are the skills, what are the capabilities and making sure that it's not, as Ellie was concerned about, like people who have a job and then say down the track, oh, I've got lived experience.

MS ABRAMSON: Yes.

MR HARRIS: It's more talking about within the workforce in mental health, what are the kinds of roles where lived experience is valuable, what's the value of lived experience, how do you bring that into the roles and make an impact. We know there's really good research that is effective, but there's also research that says, in the wrong environment, the lived experience worker can't do their work properly.

You asked a question about the clinical cultural gap. I think that goes to a lot of the work that we did in our submission around the role of psychosocial support.

So maybe to move into an opening spiel, where we were thinking is we really appreciated the Productivity Commission's focus on broader outcomes than just mental health outcomes or just health outcomes. So the issues about housing, about employment, about reduced contact with justice systems and so on, is really critical. So the human rights aspect to mental health is really broadened, and I think that's at the heart of the cultural gap, because where most of our mental health services have come from is a history of a medical model, which by definition is much narrower than a human rights agenda.

So what I've seen happen over a considerable period of working in mental health is ideas that are about, you know, human centred, person-centric, supporting people to improve, things like housing, employment and so on, have tended to come, if they're pushed into the mental health system, they get in there, just, and then at the first opportunity of reducing expenditure or focusing on our services, they're the kinds of things that are chucked out because I think the cultural dominance that you're referring to is much more about a medical model, preference and strength in those services and how they're formed and designed, and if you were looking at a departmental sense, you'd say the health department just wants to focus on the health bits, doesn't want to deal with housing.

So a lot of our submission was about so how do you bring that human rights aspiration appropriately into a mental health context. So we are arguing that the gap in psychosocial supports that you identified across the country, which is huge, is a really large part of that problem. Like solving that gap appropriately will help I think move mental health services into a better balance between health outcomes and social outcomes, pushes more towards a – like we need to move more towards the social model of mental health, and I think an investment that's smart in psychosocial supports could do that.

So that's where the psychosocial supports won't necessarily provide housing, but for people who have really complex needs, it might be providing some support for people to access those housing programs they need to access. Or it might be the thing that gets them over the line of getting a tenancy by being able to prove they've got the support that makes the landlord comfortable, so there's those kinds of things.

So I think the psychosocial component can be a bridge to supporting people to get effective support from other sectors, but also I think it's a bridge back into other mental health supports as people need them, particularly things like GPs for example, I think – I'm not sure whether you've had any submissions from GPs directly, but often what we hear is things like the – that they struggle to deal with mental health because people who have severe issues often present in a episode illness, and so that's a crisis for a GP to deal with. And their main pressure point is getting that person into more acute services, and they don't really have the time to support people around the other issues, like housing or relationships or whatever.

So I think that's where we've tried to present an approach that talks about how to fill that psychosocial gap in a way that can deliver more of those human rights outcomes, and I think trying to move away from a concept of psychosocial supports, just reducing hospitalisation rates or just saving money somewhere else in the mental health system, but actually delivering benefits that are in that human rights frame.

MS ABRAMSON: In fact, it's very helpful, Mr Harris, to have this conversation, because one of the things that came across in our report, which was unintentional by us, we had a model of stepped care and we had psychosocial running underneath it, and it gave the impression that we always thought that it was a clinically driven link to psychosocial. We didn't think that. We understand that that's how it came across, but the issue that we've asked a few other participants - that we struggle with is that psychosocial supports are often made available, because they're rationed funding things, on the basis of a diagnosis or a medical entrée into the system, and we had a conversation this morning around, well, what other models are there so that you can get psychosocial support and it's not dependent on the diagnosis or, you know, on a medical view of the world.

MR HARRIS: Look, a really good starting point to that is to look at the scale of the unmet need and try to fund to meet that gap. Most of my experience has been at the more severe end and so I wouldn't presume to speak to how to do it around low and moderate,

though I think, if you actually are able to fund to the capacity you think is required and not leave any unmet need – you know, psychosocial space, then you’ll solve a lot of those problems of rationing, and we had that very conversation this morning with a senior in person in the state department of mental health – or Department of Health, and that’s what we’re trying – like, in that Mental Health Services Plan in South Australia, that’s one of the things we’re trying to wrestle with, is how do you make the access point not feel like it’s a rationing point where you only qualify by being really ill and make it more of an access point where you feel like, yes, that person I’m talking to is here to help me and they’ve given me some options, and examples would be things like if you go through a referral process to, say, a clinician through a GP and your wait time is six months, what that effectively says to you is that your life is on hold for six months until you see this person who’s going to sort out your problem, whereas there’s lots of other things that would be really helpful, but our systems tend not to do that. So one of the – so Ellie talked about the Lived Experience Telephone Support Service and I would say that’s a really good example of how we’ve been involved in a co-design process to try to create an access point that is helpful. It’s run by people with lived experience. It’s got a counselling approach rather than a clinical kind of approach. So it’s, you know, ‘how can we help you’ as opposed to, you know, ‘tell me your problems and I’ll tell you the solution’. So it’s kind of an interesting example, and we’re talking with our state mental health people around, well, how can we do something like that for the psychosocial services that the state’s still funding here? So I’m not sure I answered your question.

MS ABRAMSON: No, but you know what? It’s helpful to know that everybody else is thinking about it as well, because that’s the thing – we’ll have a look at some of the programs that have been mentioned, too.

MR HARRIS: So I think – so part of why I think that approach is useful is that people who are looking for help – you know, sometimes it’s – something that’s really important is having someone that’s reassuring on the other end of the line, and sometimes the options that are available, they’re not very expensive. So it’s information or it’s ideas about options, it can be peer support groups or training programs. So it’s not all just about an intensive service that’s really expensive and – you know, things like Clubhouse or GROW, examples of services that are really valuable, but apart from the promotion by those services themselves, the system doesn’t actually refer people effectively to those programs.

MS ABRAMSON: No, that’s helpful, thank you.

PROF KING: What – so I mean, the services have to be there to be referred to, and that’s a problem at the moment.

MR HARRIS: Well, some are already there. But the rationing thing is partly a cultural problem, I guess, of all services being seen as part of that clinical continuum. But it’s also just – yes, not having enough resources to be able to deliver to the population as appropriate.

PROF KING: So for a person down the more severe end, having an appropriate care coordinator that stands both the psychosocial and the clinical, does that – would that help create the right pathways? So – but you don't have somebody – so you don't have to go along the clinical track to be able to access the psychosocial – so you have a care coordinator and your clinical needs may be low at the moment, but you have psychosocial needs which are much higher, and that person, because they stand that space – they deliberately stand the space, they can say, 'let me put you in contact with this service here'. It may be housing, it may be support (indistinct), support of education, it may be employment support. But are we thinking in the right direction in going down that way?

MR HARRIS: Absolutely, and that's where – like, in our submission we talked about care coordination as being a broad thing and I think probably the pathways to clinical care are really well known, you know. You know they're numbered around. If you want to get to hospital, you know where ED is. You know how to contact your GP, and that's the first point. Like, it's not as if people don't know how to get – how to contact clinical care. Whether they get it or not is another thing. But the care coordination role I think – so most of the stuff that I've seen in policy has only picked up part of that coordination role, and that's the clinical part. So – and often that's sort of motivated by things like who pays for what service and having different ways of accessing the services, and so - - -

PROF KING: It's probably more a reflection on the disjointed structure of our clinical services than anything else.

MR HARRIS: Yes. A lot of it's the Commonwealth's state of mind, basically, and moving people who – like, in the best way, people who've had that severe actual illness and needed crisis care but now they're doing quite well, transferring them to the care of a GP for their clinical needs. But in terms of the psychosocial supports, there isn't a mechanism to do that. So services like Partners in Recovery were very good at providing that care coordination that was missing, and so it's been quite disappointing to see that disappear from the landscape. But that care coordination role in the psychosocial – in the broader needs is just not there, and I don't see how to effectively recreate that within clinical settings at the moment. Like, it could be done, but it's more expensive than looking at other alternatives and I think that's where, when we're looking at the proposal around commissioning, we're very interested in how whichever model comes out – like, how do you prioritise things like psychosocial supports? Because it's likely that in some of that kerfuffle in whatever change process it is – sorry, I'm getting a bit technical with 'kerfuffle', but - - -

MS ABRAMSON: We know what it means.

MR HARRIS: Just in that change process, it's easy to revert back to a narrower model of care and certainly, I think, that's what we've seen with NDIS – you know, with the NDIS in a policy sense outside of NDIS. Regardless of what you think about NDIS itself, outside of it, it's meant that often state and federal governments have been absent from thinking about psychosocial needs of people because NDIS is coming. That's going to

deliver, and there's – you know, so it's been a really interesting reversion back outside of NDIS to a much more narrow - - -

PROF KING: Clinical.

MR HARRIS: - - - medically focused model as opposed to the social models that we've been going towards for the last 30 years.

MS ABRAMSON: Do you see any of the PHNs operating in that space in terms of commissioning or working with NGOs for psychosocial supports?

MR HARRIS: Yes. The issue, though, is the directives they have from the Commonwealth and the quantum of money they've got, aside from anything else, and so – and PHNs across the country are wrestling with that problem. Some better than others, but at the heart of it is – like, there's been some rhetoric to say, you know, that PHNs are delivering – you know, have got funding from the Commonwealth to deliver in that space. But practically, they haven't got a lot of money to deal with it and the Commonwealth programs that were there - like PIR, PHAMs and Day to Day Living - they are much smaller than they were before because the money has gone to NDIS as per the plan, but it means that outside of the NDIS, as you've identified, there's very little there and – like, one of the concerns about those kind of remnant programs is when you take them out to country areas, they get really tiny. You know, the tiny numbers of workers over the large areas. So scale is a problem in that, as well.

MS ABRAMSON: Thank you.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you.

PROF KING: Now, we've got a number of people from UnitingSA next. (Indistinct words). I should stop talking.

MS BAMENT: Are you ready?

PROF KING: No, no. Sorry.

MS BAMENT: That's fine.

PROF KING: If you can introduce yourselves, and the organisation you're representing for the transcript, and then any opening comments you'd like.

MS BAMENT: My name is Danielle Bament. I'm the manager of mental health services for UnitingSA, and I am here representing UnitingSA.

MS ROBELIN: And I'm Keryn Robelin. I coordinate with Lived Experience, 100 per cent Lived Experience Team for both NDIS and UnitingSA.

MS ABRAMSON: So, we'll try not to interrupt.

MS BAMENT: Yes. So, UnitingSA is a leading provider of community mental health services in and out of South Australia. We work closely with The Mental Health Coalition, and we've been providing psychosocial support services across the state for over 20 years. We've provided a written submission in response to the Commission's draft report, which includes a series of 28 recommendations in response to the key (indistinct) for reform. Today, however, we'll be focussing specifically on our recommendations in relation to the peer work force, and the critical role of people with lived experience play in supporting the recovery of those living with mental distress. We would describe UnitingSA as an approach around the engagement of people with lived experience, and the delivery of psychosocial support services, and the substantial benefits of this approach to support the recovery of people experiencing (indistinct) distress.

Throughout our presentation, we will be using the terms 'peer support worker' and 'lived experience worker' interchangeably. UnitingSA defines a peer worker as someone with personal, lived experience of mental distress, who is skilled in joining on their own journey of recovery to support the recovery of others. So that's an important distinction, it's not – I think, as a previous speaker sort of touched on this, it's not just about having lived experience, it's actually about having a skill set, and drawing on your lived experience to support the recovery of others.

We recommend any reforms to the mental health and supporting systems recognise the critical role of peer workers in supporting people's recovery, and that this approach is valued as at least equal to that of a clinical interventions. To this end, we note the recognition given to peer support work in the Commission's draft report, and the recommendations in relation to strengthening the peer workforce, and placing peer workers in the emergency department alternative models. We urge the Commission to go further with these recommendations, however, and call for a substantial increase investment and availability of peer support services.

In order to improve the health and wellbeing of people living with mental health issues in Australia, peer support should be readily available to all people seeking mental health assistance above and beyond community providers and emergency responses. There is a need to vastly improve people's experience with care in all clinical settings, and peer support must be widely available option to work alongside, or as an alternative, to clinical interventions. Recognition of the trauma suffered from abuse, restrictive practice and coercion across the gamut of clinical settings needs to be reflected in the Productivity Commission's findings and subsequent recommendations. Ensuring access to peer support workers in all care settings will go a long way to ensuring that people's human rights are upheld, and significantly reduce the risk or re-traumatisation, as tragically so common as a result of clinical intervention.

Over the past two decades that Uniting has been delivering community mental health services, they have continued to invest in grow up their work force. In 2018, we were the first organisation in South Australia to be accredited against The Mental Health Coalition's lived experience workforce standards. In 2019, we were awarded The Mental Health Coalition's organisation award for lived experience workforce. Currently we're partnering with the University of South Australia to progress a PHD to research and advance the mental health sectors understanding of the role, and impact of the lived experience workforce in the mental health sector.

With the rollout of the NDIS, we are seeing significant diminishing of peer support services, such as personal health and mentors program. Geoff touched on that service previously. It no longer exists as a program. There is an extension funding for the rest of this financial year, and then it will essentially cease. So there's no (indistinct). Our concern for the very real risk of a diminishing peer workforce with the rollout of the NDIS, we've created a new program to provide psychosocial support to NDIS recipients living with severe mental illness, delivered by 100 per cent lived experience workforce.

The program has recently been independently evaluated by the University of South Australia. The evaluation found quality of services delivered through this program were in line with best practice standards in recovery orientated care. However, the evaluation also recognised significant challenges in operating best practice psychosocial services under the current NDIS pricing regime. We are reporting that based on independent financial analysis a 25 per cent gap in funding.

UnitingSA operates on peer support services under recovery model of care. Through this model, peer workers give hope to people living with mental illness, through their own journey of recovery. They provide support to people to overcome personal, structural and systemic barriers to their recovery. Under the recovery model of care, recovery means walking alongside a person to help them achieve personal agency and a satisfying life, even in the presence of symptoms, so that their human rights are upheld.

I'm going to pass over to Keryn, now, who will describe the value of peer work, and the way in which this is realised within the team that she leads.

MS ROBELIN: Thank you. So, a lot of lived experience recommendations have been brought to the table today, so that got us thinking about what we mean by lived experience. When we first created the team, we considered what it was of the purpose of why we were going to do what we were going to do. So when it came to having 100 per cent lived experience, we wanted to challenge work culture. We wanted to actually see if we could dominate, I suppose, the mindset. And the guidance NDIS gave us an open window to be able to offer a hands-off approach, rather than a top-heavy governance of how we practice, so like kids in a candy shop, we said, 'Well, it's got to be 100 per cent lived experience.' But this was drawn from individuals, and their family members. It was something that they requested, it was part of the co-design that they were all involved in, from recruitment right through the interviewing, interview questions, right through to who was chosen, and holding us to account of our practice each day.

The things that didn't come up was, not one of our single people asked for a peer worker; they didn't know what a peer worker was. And they didn't know what a lived experience worker was. They didn't ask for anyone with a PHD in research of mental health distress, but they said, 'I just want someone who gets it.' And something in regards to lived experience is – something we really get is that mental health distress always comes after life impact has got to a point that it can no longer be handled by one individual.

When it comes to lived experience, I had a big think about this, and for me, lived experience and a lot of my colleagues that don't don the badge of lived experience say, 'Well, we've all got lived experience.' And I 100 per cent agree, but that is, for me, walking through what is grown from life impact, and when you think about the expertise of working with lived experience, for me, it's more about the expertise, the skills and intentionally using it to benefit another person for their growth. It is now their time. So we'll go through from story to skillset.

In the recent spate of bushfires, I think a lot of people were faced with choices to either evacuate and make drastic decisions on behalf of their own wellbeing. They knew that they were facing impending loss such as housing, stability, maybe their livelihood. Some people chose to stay behind, some people chose to wait and see what CFS could do. Metro Fire Service get paid for their job, they are experts in the field. They know less about what the voluntary fire service know about actually living in the terrain and living every day. I would like to use that as a parallel for lived experience, expertise. Recently, I was lucky enough to spend some time with one of our people. We call them our team members because they're right alongside. We don't call them our patients. They're not our consumers. We are privileged to be invited into their story. We were in the car, and the person turned to me. They had been in one of our other services prior which we've learned from, and they said, "You're from UnitingCare Wesley". That's our former name.

And I said, "Yeah, UnitingSA", and he goes, "Well, why are you so different?", and then he answered his own question and said to me, "It must be the training. You must be trained differently", and what I offered was – I said, "Well, when I think about it, we all get trained the same or we're all offered the same training at work, but all of our team were once in your shoes and were given the same message that, just like every single person that we've spent time with, for me, for the past seven years, told, 'This is it for you. It's a dead-end. Thanks for trying out adulthood. It's not going to work. You're going to be given a disability support pension. If you're lucky, you'll go on a housing waiting less, or for now we'll just pop you in a boarding house'", so they were real ending statements.

And I shared with him I was given the same, just as my colleagues, just as their team had, but we just challenged that, and we actually explored what that actually meant and came up with our own truth. Something about the lived experience workforce which I've heard people requesting for here that we already do is inclusion of the lived experience voice in every training that we offer, to the point that this year a parent of one of our individuals

that we spend time with will be teaching us on their experiences and also their loved one. We offer when there will SA health cuts recently – and over 30 per cent of our staff lost their job – we offered peer support.

While I was sitting up the back, I received an email from someone that doesn't work in our mental health services department asking if they can connect with our team rather than the employee assistance program to actually counsel through some situational stuff that's going on in their life right now, and so we responded to that. We're just offering space and really big ears. So I've been in the game for seven years actually, and with people at other services said they can't spend time along because the process doesn't fit, they don't fit in the box, their life is extremely blob-shaped, and so in doing that I think we've learnt a lot. In the seven months that my pilot has been running we have had buy-in from our team, not only into the practice, but into the culture and holding themselves account to each person they spend time with, especially family members.

The differences that we've seen is they're no longer asking what's wrong with me. They're stating now being able to define what's happening for them. Labels are turning into identity. Grief is turning into hope or an absence of hopelessness. Success is defined by the self and by family members. We celebrate those successes rather than ruminating on risk assessments, and waiting rooms has turned into breathing room. So in regards to that, what we've worked out in holding ourselves to account, learning from the past and changing those things we've learnt that culture is necessary, that training and accreditation of the lived experience skillset and expertise needs to be held up higher.

That's in some of our recommendations. We know that connection and codesign can't be done without it. It's why both Dani and I are here today sharing this delivery. So if I take us back to the bushfires, if your house was burning, would you want someone that has written a thesis on burning houses, or would you turn to a person that has lost just like you and wants to be with someone who really gets it? I will hand it back to Dani now.

MS BAMENT: So, as Keryn referenced, peer support work with as a sole support in a person's life alongside clinical services can make an incredible difference to the quality of care they receive and, subsequently, their quality of life. When making recommendations about system reform and investment in mental health services we urge the Commissioners to value peer support as an essential, highly effective and cost effective intervention with human rights values at its core that should be widely available to people wherever they are seeking assistance to overcome their distress. We urgently need to see the reinstatement of peer support services, such as Fams, that have been lost and continue to be diminished by the loss of state and federal funding with rollout of the NDIS.

PROF KING: Thank you. I'll just ask one to clarify, sorry, Julie. Just on the training for the peer workforce, so you said two things, Keryn, that I just want to make sure I've got clear. So all training should include the lived experience aspect.

MS ROBELIN: I believe so. If we're going to be looking at facing the life impact alongside an individual, we need to understand what that terrain is.

PROF KING: Okay. And lived experience workers need to have the right skillsets, but I took – and I'm not sure if I've got this right, but I took from what you said they don't need different training to people without lived experience. It's the same training, but the training has to be right for everyone, if I can put it that way.

MS ROBELIN: Did you want to respond to that? I've got an answer for me, and when it comes to that I believe that if I was to go to a hair salon and I went to Just Cuts for having some colours, I have three levels of colours in my hair, I'm in the wrong salon. I would be looking for someone that has done about five years minimum in hair colourisation. I would not risk myself in the hands of someone that had been given a watered-down version or a short course version of what takes years to actually learn from.

So I believe that the expertise, if anything, should offer resources to future training of those that are operating effectively. We've got Cert IV in Peer Work here in South Australia. That's an accredited course nationally, and that was derived from peer champions and we codesigned. So it's already in place. I do think that if you are going to put on the badge, you need to have gone through a gateway of understanding what that means, the significance that it is not your story, it is not your time and how you're going to use those tools that you've drawn.

MS BAMENT: So in relation to our workforce development and training, we have, regardless of whether someone is in a peer work position or community support worker, a minimum Certificate IV in Community Services or Mental Health. What the – I guess the standards around peer workforce and that as a skillset is still something that's developing nationally, and we're very keen on participating in that. So in terms of the training, yes, there is a base level of understanding mental health and people living with mental distress. For our peer workers we certainly do value very highly the peer mental health certificate because it trains in the skilful and mindful use of their lived experience.

However, their availability of workforce with that certificate is really small and we can't fill our positions with that accreditation alone. So we through our recruitment – that's a key part of recruiting for peer workers is associating a person's ability to use their lived experience in a purposeful and safe way. So we do that through recruitment, and then it's developed through supervision. We don't have any specialist training at the moment because it's not as valuable outside of the peer Cert IV.

PROF KING: Thank you.

MS ABRAMSON: No. Good. Thank you very much.

PROF KING: Thank you then.

MS ABRAMSON: We will let you get back to your day jobs.

PROF KING: Next person is Melissa, Melissa Raven. So welcome, and if for the transcript you can state your name and your current (indistinct).

DR RAVEN: Yes. I'm Melissa Raven, and I am a research fellow at the University of Adelaide and the Clinical and Ethical Mental Health Group.

PROF KING: Any opening comments you would like to make?

DR RAVEN: I'm happy to launch into my presentation.

PROF KING: Yes, please.

MS ABRAMSON: Feel free to.

DR RAVEN: I'm torn between looking that way and looking this way, and so I'll probably look up, swivelling my head quite a lot. I have three key messages to try and put across today, and I see what I've written right at the front. The first key message is that the decision to exclude social determinants of mental health is very problematic and I think it calls into question the claims that the recommended reforms will improve population mental health and population wellbeing, and I'll elaborate on them shortly.

My second key message is that there is a taken for granted assumption that treatment is the answer, that it just needs to be the right treatment in the right quantities to the right recipients. This assumption is not evidence-based at a population level and in fact there is considerable evidence that challenges it.

My third key message is that many economic analyses, including several analyses that are cited in the draft report, and some of the analyses in the draft report, include problematic, non-evidence-based assumptions or assumptions that are based on very weak, problematic evidence.

So moving to elaborate on my first key message, I think the decision to exclude social determinants of mental health is very problematic, and as I said, it calls into question claims that the recommended reforms will improve population mental health and population wellbeing. The draft report explicitly rules social determinants of mental health out of scope; on page 123 it acknowledges the social and economic circumstances of people's lives having substantial influence on their mental health.

“While acknowledging this important link, this inquiry focuses on improving the way systems and government services can support people with mental illness across all walks of life” – and I have no problem with that – “and contribute to population wellbeing, and that is what I question.

For example, while this inquiry has examined how to improve accommodation options for people discharged from mental health in-patient services, and strengthen mental health

services for people without stable accommodation, broader community-wide problems of homelessness and housing stress will not belong to this inquiry's scope.

Additionally, the draft report specific rules the adequacy of the Newstart Allowance out of scope, and it says, "Where the payments are at a level that represents an adequate safety net is contentious, particularly in relation to Newstart, but as noted in section 40.5, this concern is not specific to people with mental illness and is outside the scope of this inquiry".

I think it is very problematic to take the stance that things that are not specific to people with mental illness are not important determinants of mental health.

PROF KING: Because I think your interpretation of why we didn't go there is incorrect. We don't believe they're not important determinants, it's simply that we have to draw boundary – so we do an entire inquiry on the right setting of Newstart. We could, and in fact we have, done an inquiry where we have certainly hundreds of pages on public housing and the ways to improve public housing, the property – or climate change, we haven't done climate change.

So it wasn't that we don't think they're important, it's just that if we didn't draw a boundary somewhere, then after 18 months we wouldn't have actually addressed a lot of the issues that we see as being core. So I understand your position, and we had to make a judgment, and I understand that some people will say you made the wrong judgment, particularly on climate change, which I don't think we even mention in the report, there's been a lot of criticism on that. But I'm not sure what else we could have done.

DR RAVEN: Yes, I understand that, the potential scope is an extraordinary broad one. It would not be possible to focus on everything. However, what is problematic is that having made that decision, there are these claims that the reforms will improve population mental health and population wellbeing, and I just don't think those claims are terribly accurate.

Also I note that the Royal Commission in Victoria, when it was first announced it was an inquiry into the mental health of Victorians, but quite quickly it narrowed down into an inquiry into the Victorian mental health system. So I think it is more appropriately benched, I think – in the final report I would like to see claims about improving population health gone – in fact I actually would like some acknowledgement that this – the proposed reforms are not going to have an appreciable – or are unlikely to have an appreciable effect at a population level. Anyway.

Actually, that sort of makes relevant sort of my next few points. However, I'm still going to say I think it is hard to think of a better opportunity than a Productivity Commission inquiry into mental health to evaluate economic social determinants of mental health. I think it is a – from my perspective it is a lost opportunity, and that would include the Newstart Allowance and other welfare payments which affect other social determinants of mental health, such as housing insecurity and food insecurity, and tend to have a snowball effect.

Again, some of my next stuff has sort of become irrelevant. I would like to say though there is abundant evidence about the importance of social determinants of mental health, both in Australia and internationally, but unfortunately it just does not get the recognition that it deserves, that it warrants.

But I will draw your attention to a submission by some other people, submission 157 by Leach and colleagues – Liana Leach and Lyndall Strazdins and colleagues, which does focus – it focuses on social determinants of the health of workers, which of course has economic implications. They draw on the research of Geoffrey Rose about distribution of disease burden in the population, and I'm just going to quickly read an excerpt from their submission:

“High risk individuals are only a small proportion of the overall population and so account for a small burden of disease. It is the people at the centre of the distribution” – as in a graphical distribution – “exposed to only a small element in risk, i.e. low level symptoms, who are responsible for the largest burden of disease, thus the greatest social and economic benefits will only be realised by shifting the distribution of risk in a positive direction”.

By that they mean shifting the mental health of the population as a whole a little bit in a positive direction. So it's not making massive changes to a lot of people, but just a little bit. And because there are so many more people to the left of the distribution, that can have quite substantial aggregate effects.

The last thing I'm going to say about social determinants of mental health is, unfortunately, research into social determinants of health and mental - including mental health are complicated by the fact that many factors and many outcomes are interrelated. There tend to be relatively weak links between any one factor and any one outcome, and this makes it hard to produce strong evidence.

However, small changes and multiple factors can have large aggregate effects in relation to multiple outcomes, including other factors. For example, poverty, unemployment, housing and security, and permanent security influence not only physical health and mental health, but also influence educational outcomes, vocational outcomes, and crime, and they all potentiate one another. So, in the diagram, there's arrow going in all directions.

Okay, one last thing. Some useful research comes from so-called natural experiments, including abrupt economic changes, that have demonstrated that mental health and suicide rates are significantly influenced by abrupt changes in social determinants. In America, Costello et al, discussing the establishment of a casino, of all things, on a North American Indian reservation, which created jobs, reported that - and then come intervention, they leave the employment generated by the casino, and then come intervention that moved families out of poverty for reasons that cannot be ascribed to family characteristics had a major affect on some types of children's psychiatric disorders, but not on others.

So it wasn't a - you know, it wasn't a panacea, but it certainly helped the community. And on the other side, financial austerity has increased suicide rates, and Greece in particular has found that - well, suicide rates in Greece and other European countries have been on a remarkable upward trend following the global recession of 2008 and the European sovereign debt crisis of 2009. So, okay, enough about social determinants. I mean, you know, maybe I'll be lucky and in a year or two, there will actually be an inquiry into the social determinants of mental health. I would love that to happen.

Right. My second key message is the assumption that treatment is the answer at a population level. I'm not saying that treatment is not the answer for a lot of individual people. But there is a taken for granted assumption that treatment is the answer generally; that it just needs to be the right treatment in the right quantities to the right recipients. This is not evidence-based at a population level, and in fact there is considerable evidence that challenges it.

Now, first of all, there is no population evidence that directly demonstrates that increasing treatment at a population level increases population mental health. Now, I'm taking a bit of a risk by saying that, because obviously I don't know all the evidence.

PROF KING: All the evidence, okay.

DR RAVEN: But I have searched. I cannot find evidence at a population level, and there is mounting population evidence that increasing treatment does not increase population mental health, and I'm pleased that, in the mental health literature, there is increasing questioning of the assumption that scaling up treatment will significantly improve population mental health. There have been multiple studies from Australia and other countries that have produced evidence that that is not the case.

And some of these articles, quite usefully, have the answer in their titles. Mulder et al from New Zealand published an article in 2017, 'Why has increased provision of psychiatric treatment not reduced the prevalence of mental disorder?' Bastiampillai et al, from here in South Australia, 'Has the UK improving access to psychological therapies program and rising antidepressant use had a public health impact?' The answer is no. Tony Jewel, here in Australia, 'Australia's Better Access Scheme. Has it had an impact on population health?' The answer is no.

Furukawa and Kessler, last year, published an article, 'Why has the prevalence of mental disorders not decreased as treatment as increased?' And Jorm again, 'Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries.' And again, the answer is no. Now, some commentators argue that the lack of improvement in mental health is due to inadequate or a non-evidence based treatment, and that the solution is more and better treatment.

However, I have, and I'm not the only one - it is more likely that the lack of action to address social determinants of mental health is the key issue.

MS ABRAMSON: Dr Raven, I'm sorry to interrupt you. We do have some time pressures on us.

DR RAVEN: Okay.

MS ABRAMSON: And so perhaps if you could, assuming you've put in a submission, or a lot of the references that you've referred to are in written material that you've provided to the Commission. So if you could perhaps address the things that, in the last - in five minutes, the things that are really pressing for you.

PROF KING: That being said, I'm about to ask a question. So, in the literature, and we're aware of - well, I've actually read some of that literature, but not all of it. So at a population prevalence level, there's no evidence. For example, you don't see better access in the population level (indistinct) evidence, and that's Jorm, one of Jorm's favourites. And on your basis of the social determinants of health, you wouldn't, unless you addressed those issues such as housing, poverty, and so on, you're not going to see that.

But do you see - is there work that's being done on - do you see a reduction in the intensity of mental health issues? So there's a prevalence issue versus an intensity issue.

DR RAVEN: No. I can't say off the top of my head, but I know some of these Chinese studies have looked at - - -

PROF KING: Intensity.

DR RAVEN: - - - criteria such as, you know, scores on the (indistinct).

PROF KING: Yes, okay.

DR RAVEN: Or something like that. So it's not just the numbers of people that have achieved it, it's also a - you know, it's the overall burden of mental disorders. There's just not - - -

PROF KING: Okay. No. So that's a good point. Sorry, and just your third one was?

DR RAVEN: My third one, very briefly, is what many economic analyses, including several economic analyses that have been cited in the draft report, and some of the actual analyses in the draft report include problematic, non-evidenced based assumptions, and I'll just very quickly mention two - two examples in the Commission's modelling that I think are problematic, and I'm looking at - in Appendix F.

PROF KING: Yes.

DR RAVEN: At table F3. Firstly, in relation to change - - -

MS ABRAMSON: Our modellers will be very happy that someone's read Appendix F.

PROF KING: Other than me.

MS ABRAMSON: Other than Stephen.

DR RAVEN: I'll tell you, I went right through Appendix G, because somewhere in the report it says Appendix G, and I finally found out that it was meant to be Appendix F.

PROF KING: Sorry, Appendix F and the assumptions that are - - -

DR RAVEN: Yes. In relation to changes in workers' compensation for mental health claims, no reference is cited for the assumption time on workers' compensation will be halved. Now that's a pretty bold claim, but no reference is cited. Most of the items in that table do have references cited, and there's not any reference cited on pp.76-78 of the draft report where it's discussed.

PROF KING: Time on workers' compo.

DR RAVEN: And I will just quickly draw the Commission's attention to a Canadian study by Ebrahim et al, 'Association of psychotherapy with disability benefit claim closure among patients disabled due to depression', which found, paradoxically, receipt of psychotherapy was independently associated with longer claim - longer time to short-term disability claim closure, and faster long-term disability claim closure in patients with depression. So sometimes there are paradoxical effects.

And secondly, in relation to improved social and emotional learning in early childhood and school education, I think the projection to adult employment outcomes is extremely problematic, and I just point out the cited reference, (indistinct) et al 2012 actually cautioned given that more than half of the studies reported only post-test data collected less than half a year after the end of the intervention, conclusions about the lasting effects of these programs need to be made very cautiously. So I really do not think that's the (indistinct) supports the claim that it is cited to support.

And my final comment on economic analyses is that actually these sorts of problems are extremely common in the - in the mental health economics field.

PROF KING: Yes.

DR RAVEN: And that's (indistinct).

MS ABRAMSON: Thank you.

PROF KING: Thank you for that.

MS ABRAMSON: Thank you for that.

PROF KING: I think I know where we did the workers' compo half lines, because there's - well, I can't be sure there's actually natural experiments, because some states have already done the intervention that we were suggesting, and some states haven't.

DR RAVEN: Can you please tell me that in the final report there's going to be a detailed - you know, there's going to be tables whatever it is on steroids, with lots of references cited to lots of (indistinct).

PROF KING: Hopefully so. I know the guys are working on it as we speak. Thank you very much. Caroline Johnson next. My co-Commissioner is going to get out the - - -

MS ABRAMSON: The co-Commissioner is a lawyer by training, and therefore there's process.

PROF KING: I can see the thumb screws are getting out on me regarding the timings and so on, so if you could please introduce yourself, any organisation you're representing.

DR JOHNSON: So my name's Caroline Johnson. I'm representing the RACGP, Royal Australian College of General Practitioners, not to be confused with (indistinct) who was representing general practice and mental health standards collaboration.

MS ABRAMSON: Yes.

DR JOHNSON: Although we obviously have some overlap. So we're a very big college, the largest professional medical practice for colleagues representing 42,000 members. Our members provide over 158 million services to about 22 million Australians every year. So there's a lot of activity in the mental health space. So I was really pleased to come and talk and, like Jeff said, I assume you've had a chance to read our submission. I'm sorry, but I guess I'm prepared to sort of pick which one you'd like to ask questions, or like me to talk to.

I mean, obviously the response we wrote was very much sort of in defence of the concept of mental health plans, and maybe a little bit in defence of the concept of better access, but with an acknowledgement that both these initiatives are well overdue for a bit of redesign and a rethink to address some of the concerns, rather than just sort of getting rid of them altogether, and then also, of course, the issues around funding of general practice, which again can sound like doctors are talking about being paid better, but I think it's much more about, you know, equitable reward for doing mental health work compared to the rewards doctors receive doing physical health work.

Because otherwise the profession - and I train GPs, and I've been doing that for 20 years. The interest in doing work that is poorly remunerated and very emotionally demanding and difficult gets less and less, without some rewards, and I don't think they should just be financial, but I do think we have to acknowledge that mental health consumers deserve access to the same quality care and the same dedicated professionals as people who need physical health care, which comes back to that issue, you know, if we tried to a

Productivity Commission on the whole of physical health, we wouldn't be talking about everyone altogether.

PROF KING: No, that's right.

MS ABRAMSON: I think you might kill the Commissioners if we had to do it on the whole of the physical health (indistinct).

DR JOHNSON: But here we are today with this struggle about - I mean, you know, high prevalence and - or low prevalence disorders, and the reality is, in general practice we see all these things. We also see the missing (indistinct) or they're not missing to us, and so I guess, just to frame that conversation, and I don't want to really neglect either side of - or breadth of what mental health wellbeing is, because we're also interested in early intervention and prevention. We're also interested in the fact that, as the previous speaker said, a lot of the interventions don't actually work.

We would probably believe that there's still reason though for hope, and that if an intervention doesn't work, the main thing is that people stay engaged in care, and I think general practice plays a really important in keeping people engaged in care and keeping them - to have hope even when some of the interventions we're trying aren't immediately effective, and there's a lot of complex reasons around that. So I don't know where you want to go with the short time you have with me, what things would be most useful to you.

PROF KING: Mental health, as we mentioned at the beginning, mental health plan and better access would be the two that I'd want to focus on. Yes.

MS ABRAMSON: Also, and I just had one, if I could, Stephen.

PROF KING: All right. You go first.

MS ABRAMSON: We've heard a lot today, and yesterday when we spoke to consumer groups about the importance of lived experience, and at the Commission, we're really thinking hard about how we make a meaningful thing. It's not a tokenistic, well, you consult over here. Because you've got a lot of experience in working in the area, I'm interested in your experience where you've seen it work well, and it's a co-design, co-production.

DR JOHNSON: Well, I hope this isn't controversial to my consumer colleagues to say it, but I think most of the best co-design happens actually in my consulting room, which is where you have a relationship-centred approach, and you say to the person that needs help, well, what do you want? So for many, a mental health treatment plan is so important, because I say, there's a bit on the form that we're meant to write what your goals are. But what are they?

MS ABRAMSON: Yes.

DR JOHNSON: And let's not do the plan today, because you're not quite ready to declare what you think you want to achieve. So I think, you know, we have to remember that it does happen every day in the privacy of a clinic or a consulting room, or anything else. At a broader level, I think, certainly the GP land, we were probably one of the first organisation, I believe in the world, when 20 years ago we agreed with consumers and carers that if we were going to set the standards for mental health training for GPs, we definitely needed both people with lived experienced, carers as well around the table, and to this day they are contributing.

I think more could be done in that space, and I think it's really exciting to hear about models like co-design and collective impact, and I do think that the more consumers have leadership in that, the more bang we'll for that. I think, unfortunately often clinicians find that scary, because the true believers kind of go, well, we know what you're saying, but we're also a burnt out like system.

MS ABRAMSON: Yes.

DR JOHNSON: And I think that's a shame, but I don't think that's a reason not to keep trying. Yes, so I'm all for it, I guess, basically, and I think you learn - I mean, I spent a lot of time teaching my young doctors, you'll learn more by listening to and being effective and honest with the people who are coming to you for care than just following guidelines. And again, I think GPs are really good at that. So we grapple all the time with this issue of, you know, you have to have a diagnosis to get into service.

GPs are very good at being pragmatic about those kind of things. When is it safe to label? When is it not safe to label? Does it mean you get a service? Does it mean you disadvantage a consumer? That kind of stuff, that's kind of bread and butter for GPs and working in that level of uncertainty. Young doctors who come to general practice are often quite shocked, because they come from the hospital and they take a big pay cut, and then they find they have to deal with what are (indistinct) and really complex tasks.

And of course, what happens to them is they say, gee, maybe I'd rather just do a bit of skin cancer medicine, or a bit of cosmetic medicine, because this work is really, really, hard. So certainly, I've made my career and goal to say, well yes, it's hard, but it's really important. Because I do think, while I agree you can't necessarily say that population level - we can be sure this makes a difference, I think that it's a non-brainer, that it's really important because of the prevalence and the rate of mental distress that we should be doing things in a primary care setting.

MS ABRAMSON: Thank you.

DR JOHNSON: I think I've gone off a bit.

MS ABRAMSON: No, no, no, it was helpful. Thank you.

DR JOHNSON: So turning to better access, I guess - I mean, I'm really lucky because I started my mental health and advocacy career in the late 1990s. I was a GP educator and we were running courses for GPs, and we started looking at the literature, and at that time, a lot of people were saying, GPs are missing mental illness. We just need to train them. So we did that. We trained them. Then the opportunity to set up Better Outcomes came along at about the same time as in the US Wagner was describing his chronic disease model of care, which said, you know what, honing clinicians isn't enough. You also have to (indistinct) people or find the cases of people, because people won't necessarily come.

And guess what? Even that's not enough. You actually have to offer them an intervention that probably works, but even that's not enough, because it won't work all the time. You actually have to give people self-management skills and you have to make sure they come back and keep coming back for care until you actually get an outcome. And it was a really fantastic concept, and two colleagues in Washington Uni, (indistinct) and Elizabeth Williams, a psychiatrist and a GP, said let's actually implement this because we want to see that we don't actually believe that the problem is we're not finding people with mental health problems.

The problem is we're offering them treatment, but we're not actually doing enough. If I could do that a bit better, it's not enough, and actually treating the people who already have a problem is probably more important. So that's when these collaborative care models for depression emerged, and really, Better Outcomes was really designed on that. You know, you might remember, it said we'll give you a financial reward if you actually bring the person back and actually make sure that the intervention you offered got them better.

But for various sort of policy issues and MBS funding implications, it got changed to Better Access. Now Better Access was good, because it meant you didn't have to have training to actually refer people, which addressed the problem of the reluctant GP, the one who wasn't being trained, but it also actually really got GPs doing more training. So now we can say 85 to 90 per cent of GPs have to the training. So the training that we all agreed, and it was multidisciplinary, (indistinct) carers, psychologists, GPs, policy makers, we all agreed, this is the kind of training we want GPs to have, and 90 per cent of GPs have the training, but still we get anecdotes that they're not all doing their job.

I personally think that there's lots of other reasons other than training why we mightn't always get the quality we're looking for, and I think that's the area where we could probably do the most (indistinct) and I don't want the message to come out that we don't think we should train GPs. Of course we can always improve our training.

PROF KING: Yes.

DR JOHNSON: And I've spent a lot of my career trying to do that, but I think you can't really train someone and then put them into an environment where they can't exercise their training - - -

MS ABRAMSON: Yes.

DR JOHNSON: - - - because the system works against them, and the biggest issue there, of course is, the fee for service model that encourages short consultations, and that's why the college chose to clarify that in their second submission which is whether to look at the financial rewards for doing mental health treatment plans relative to the income you can generate with the assistance, for example, of practice nurses.

PROF KING: Yes.

DR JOHNSON: You know, it's actually an economic death for general practice if you - if you said, like I do, 'I'm going to do 50 per cent of my practice doing mental health work', I actually generate about 25 per cent of the income of my colleagues who are doing - now, I choose to do that, but that's not a solution for the whole profession. If you're really saying that everyone's going to general practice, you need to make a system where mental health care gets the same reward as you get for doing physical health care, and I think some of the recommendations we've made are around that.

When it comes to the mental health treatment plan, I actually did my thesis on looking at, well, I got interested in these outcome measures of monitoring and if one case is right, well, how do you actually know that someone's getting better, and I did some case studies and talked to GPs considering without carers, and what I realised for most conversations is that the mental health treatment plan is really a key tool for engagement in the process, particularly for the GP.

I don't think it's necessarily shared with psychologists. In fact, some psychologists I use actually say on their website, 'We just need a referral. We don't need to see the mental health treatment plan'. I would argue that's possibly a failure on our part to get into professional practice happening, but I think it's also acknowledging that maybe for the psychologist the plan doesn't matter, but a plan done properly for the consumer and the carer.

And the GP is really important because it doesn't just cover what's your diagnosis. It covers, what are your goals, what have you done before? If it didn't work, what are you going to do differently? It also covers what kind of therapy is the best therapy for the kind of problem you have, and everyone is alluding to, it's not always CBT. It's not always even a small list of psychological interventions. So a plan should be able to introduce other things like physical health care, like psychosocial things but the mental (indistinct) hasn't fully realised that because it's been overly focussed on referral from a GP just like - - -

PROF KING: Okay. So can I jump in there.

DR JOHNSON: Yes.

PROF KING: So one way would be to try and transform the mental health care plan.

DR JOHNSON: Yes.

PROF KING: And the GP's role so that it included things like psychosocial support.

DR JOHNSON: Yes. Yes.

PROF KING: The alternative is to say, like it or not, we have the current fee for service model for GPs.

DR JOHNSON: Yes.

PROF KING: We know there are a range of GPs, some who are very interested in mental health, but others who are saying, 'Look', as you said, 'because it's death to my practice if I spend more time doing this. I'm more - I've got my full book with short and a number of long consultations during the day and that's how I want to run my practice'.

DR JOHNSON: Yes.

PROF KING: So is it better to actually say, and I asked a similar question earlier on today, to have an, external to the GP, triage process, along the lines of what they've got in WA, where the GP can say, okay, there's a mental health issue here. I'm going to refer you on to this. I don't need to do the mental health care plan.

DR JOHNSON: Yes.

MS ABRAMSON: So they can - - -

PROF KING: They then contact the individual and there is much more time and space to triage, much more ability not just to send them down a clinical path, but also the psychosocial form.

DR JOHNSON: Yes, so that is already happening. So certainly the PHN in my area already offers a, you know, front door approach, no wrong door. I also sit on a group that's looking at developments in national standards for this assessment and referral process and it's been really interesting to think about what the PHNs are offering in that space and my concern is, a lot of them are actually offering a non-clinical triage, so someone turns up, even if the GP writes a letter saying, 'This person's got a problem. Fix it', and someone with no clinical training asking the person a few questions over half an hour without thinking about the more holistic approach.

Now, I would argue, if GPs aren't doing that, let's fix the GPs who are; let's look at the reasons why they're not; but still may have no problem with having that as a backup for when GP services fail, and there are a lot of reasons why GP services fail that have nothing to do with GPs, which we could talk about later.

So I think that's good as a safeguard, but I don't think it's the model we should aspire to because we know that people, especially with serious mental illness, also have quite complex physical health care needs, and if you do something that says, 'Let's carve out' - I mean, Americans use this language, carving out behavioural care from physical health care. Let's just make it a separate thing and cut the body in half. There's your mind and there's your body.

PROF KING: Okay, so - yes.

DR JOHNSON: And I don't think that's a good principle. In fact, WONCA is a welfare organisation produced a document a few years ago looking at countries all around the world with much poorer health systems than Australia, and when they integrate mental health care into primary care it reduces stigma, it reduces discrimination. It makes care more accessible. It ensures that physical and mental health care get addressed together. So we would prefer that those models are better integrated into primary care, but with an understanding that that won't work in all situations, and clearly there are some areas, but I think we're failing to look at the reasons why it's not working in some areas, and that I think is more important.

PROF KING: Okay. Can I - I want to push back on that a bit because I know that it's - you're creating separation, but if I go in and my PSA is high, then the doctor will refer me off down a particular - to a urologist, I think, to a specialist and then that specialist then, you know, keeps my doctor in the loop and I may have, you know, a sore hand at the same time, and so my GP is in a sense managing a whole range of referrals. Why is it that if you say the GP is also then referring off to the mental health service, why does that create a difference or a gap?

DR JOHNSON: Well, that's a different - that's a slightly different question than the one you asked before which was, will the GP just flick a person off without assessing them. So a person that I refer to a physical health specialist, - - -

PROF KING: There still has to be an assessment obviously.

DR JOHNSON: - - - still gets an assessment from me. So for example, the chap who comes in saying, 'I want my PSA checked', my job as a GP is, as a steward of very expensive health services is to say, 'Well, do you really need a PSA? What's your risk? Is it an appropriate screening test? What do the guidelines say', and PSA is a particularly complicated example.

PROF KING: Yes.

DR JOHNSON: Because the evidence for referring someone off for a testing is contested.

PROF KING: Yes.

DR JOHNSON: But that's the GP's job, and also to say, 'Well, hang on a minute, while you're also here for your PSA, did you know that actually you're much more at risk of dying because of your family history of, well, this or that'.

PROF KING: Yes.

DR JOHNSON: That holistic approach is what GPs are trained to do.

PROF KING: Yes.

DR JOHNSON: And so if you said to someone, 'Off you go somewhere else', then the GP might not do that. What you're really asking is, could a GP do a referral without a mental health treatment plan.

PROF KING: Yes.

DR JOHNSON: And the answer is clearly yes, there would be some GPs who would say that's a fantastic thing because it would save me a lot of time and save me a lot of money, and I think the services we now have already address that issue, but I don't think it's best practice. I would prefer that my colleagues say that if someone has a mental health problem they deserve the same kind of assessment as you would offer someone with a physical health problem.

So if someone comes in with high blood pressure or breathlessness, they need a cardiovascular exam and a respiratory exam.

PROF KING: Yes.

DR JOHNSON: If someone comes in and says, 'I'm really, really sad or really worried', then I think they deserve the holistic primary care assessment as well. GPs are trained to do it. I don't see why you would want to carve it off for the majority. I think, and this is one of the problems we are losing in our Australian health care system, is this notion of generalism, but there's lots of evidence about the more strong generalist workforce you have, the better you are able to provide services.

Paradoxically maybe, because you're actually using people who theoretically know less complex stuff, but it's the ability to apply all this complexity at a grass roots level means that we can address the care for people in rural, urban settings and people with a lot of diverse needs, and that's something that I think only people working in general practice really understand fully, but there is research to support that model.

But I hear what you're saying. I think there are GPs who would say, 'I'd rather not do that'. My job with young doctors is to say, 'Actually, then, are you really a generalist because if you want to be a skin cancer doctor, then be a skin cancer doctor'. We need to bring more people to this notion that we need doctors who are trained to lead teams, and

this is the other point that, if you're going to say that we want generalists who can lead health care teams, then you need to make sure you have mechanisms where the team actually function, but at the moment we don't have that. We've already seen the report you mentioned. Case conferencing doesn't really work.

MS ABRAMSON: Yes. Yes.

DR JOHNSON: Telephone consultations don't really work. Unless a person is sitting in a room actually seeing the doctor, it doesn't work.

MS ABRAMSON: Yes.

DR JOHNSON: The only way we can pay our practice nurses is because we generate income for doing all these plans so that we can pay the nurse's salary. We used to be able to use the nurses for wound care and immunisation, but now, unless I walk in the room and say, 'Hello, Beth. The nurse is just going to give you an injection', we don't get an income for that service. These kind of stupid policy things that don't actually foster team work.

PROF KING: Yes.

DR JOHNSON: So, and that's why the college has done all that work on we need a, you know, patient-centred medical home because it's saying, of course it's not just the GP.

PROF KING: Yes.

DR JOHNSON: But it needs to be in the community in that environment, and there's some really exciting things happening in general practice now. Everyone's gotten a bit sick of waiting for the government to solve the problem, so you do see clinics self-organising now, often larger clinics, which is a threat, of course, to smaller clinics. It's a threat to community for rural-based settings. Recently one of these larger clinics in a rural setting had serious financial problems. There's a lot of threats because the small business model is challenged.

PROF KING: Yes.

DR JOHNSON: But I would argue they're the kind of things that need to be addressed, rather than saying, well, some GPs aren't doing the right thing. Therefore let's just, you know, forego that process.

MS ABRAMSON: In fact, it's a general push because the private health insurers are making strong representations - - -

DR JOHNSON: Yes.

MS ABRAMSON: - - - to be able to do much more in mental health in the community.

DR JOHNSON: Absolutely. Yes.

PROF KING: All right. Thank you so much.

DR JOHNSON: Okay. Thanks very much for having me.

MS ABRAMSON: Thank you.

PROF KING: And Michael Innes I think is next. Michael, if you'd be able to introduce yourself, state your name and any organisation that you represent for the transcript and then any comments you might have.

PROF INNES: Thank you. Thank you for the opportunity to make a submission. I make the submission as an individual.

PROF KING: Yes.

PROF INNES: And so I have been associated with many psychological institutions across the years. These views are my own as a result of my analyses of the literature and the practice of psychological science and they should not be attributed to any institution with which I have been associated.

I have to declare that I am not a clinical psychologist, a registered psychologist and should not be referred to as a psychologist. To do otherwise is to risk my being fined substantially by the Australian Health Practitioner Regulation Agency. I call myself a behavioural scientist with extensive training and experience in psychological methods.

My comments pertain to models that affect the workforce and I declare my awareness of the submission that we made to the commission by the Australian Psychological Society, and their recommendations to the Commission made at pages 13 to 16 of their submission.

My concerns are that there were no references made in the draft report of the Commission, or in the submission by the APS that the possible and timely impact of the government's automation and artificial intelligence affecting professional education and employment.

Access to health services related to mental health continues to emerge as a crucial factor, but the absence of the likely impact of artificial intelligence, I think, overlooks a major future opportunity for treatment and also is a threat to the workforce and the community.

The discipline professional psychology currently provides services to assess clients' state of wellbeing in mental health to enable a formulation or diagnosis of any condition which can undermine a person's capability to function; to design and implement an intervention

to treat the identified condition and evaluate the positive and negative outcomes of that intervention.

These four components, assessment formulation, intervention and evaluation are the pillars of psychological treatment. These components are all capable of being significantly augmented and/or replaced by machine intelligence. AI presents a threat to the employment of skilled and professional people across the spectrum of occupations.

The development of AI has been proposed, however, not to have a likely effect upon sections of the workforce such as psychologists because of a requirement that such people to have skills, the so-called soft skills, including empathy, which cannot be provided or emulated by machines. We believe this assumption to be false. Psychological treatments can be provided by machine and will be more reliable and valid.

The use of AI can be shown to elevate the reliability and validity of all processes within the four components I have enumerated. Machines can access information regarding the efficacy of measurement, interventions and evaluations faster, more reliably and with stronger differentiation of validity than can human operators, and I'm dealing here with a narrow definition of artificial intelligence. This is based upon presently available machine learning systems. These interventions can be replaced.

We're not talking about Skynet going self-aware in August 1997. We're talking about narrow definitions of AI. If general AI systems emerge, then there is the prospect of very widespread replacement of human psychologists, but the threat of already available narrow band systems are imminent and real.

So attention needs to be paid to both the impact generally of AI development on the employment of large sections of community which is outside the remit of this investigation, with implications for the mental health of the general population and also to the provision of services to the population through machine intelligence. That will however, if that occurs, and is occurring, there will be possible severe impact on the employment prospects and the training and education of psychologists in the workforce.

One can argue that the even if there is a general overtaking of provision of the workforce by machines, there will continue to be a need for highly experienced experts to influence and monitor the development of automated services, but as AI systems evolve and intrude into higher and higher levels of delivery, the opportunity for psychologists to gain experience and thus expertise will be reduced and a cohort of experts will be shrunk in a circular fashion.

We need also to be cognisant of the evidence, the strong evidence, that experience per se is not a good predictor of success as a psychologist. There are wide individual differences in capacity and narrow AI systems will be able to replace in an ascending manner the capabilities of increasing numbers of trained psychologists. These concerns have expanded in a number of recent references which I can give you access to.

I also point to the work of the economics Nobel warrior, Joseph Stiglitz, on the implications of poor - of unemployment of artificial intelligence, and a clear, comprehensive and (indistinct) review of the issues associated with developments in artificial intelligence can be found in the Australian Council of Learned Academies report authored by Professor Toby Walsh and released in late 2019. That's my statement. Thank you.

PROF KING: Thank you. So, and I won't pretend to be up-to-date on the cutting edge of AI and where we're sitting at the moment. My understanding is, certainly research up until a couple of years ago is that while AI and machine learning from large data can be used to replace parts of jobs, so you have things like the KPMG, I think it was, report from the UK which always gets quoted, and as far as I can tell that makes the mistake of confusing loss of jobs with loss of parts of jobs.

And certainly up until a few years ago the best evidence from AI research was, yes, machines and 'intelligent', and I'll do the finger quote, sorry for the transcript, because it's not really intelligence, but they are able to - well, they are best - the best outcomes occur when you have the humans and machines working together, not the machines replacing the individuals, which shouldn't surprise us because we have more than 250 years of industrialisation where it's very rare for the machines to replace the humans, rather the machines and the humans work together and there's an increase in productivity and that's been the main cause of economic growth for the last 250 years.

Why shouldn't we be taking everything that you've said and said, 'This is brilliant. Psychologists will be so much more effective'. Will there be less demand for psychologists? Well, we don't see that in other areas where there's a massive increase in productivity. In fact, it means that the current waiting lists and shortages that we've referred to in the mental health system will hopefully be massively diminished, and we'll end up with a great win for the consumers who are the ones we care about. So what's wrong with my picture?

PROF INNES: On the face of it there is nothing, absolutely nothing wrong with your picture. I think however, and we believe, however, from our analysis of the the work practices of psychologists is that they are in fact not able to provide things which cannot be done by machines.

They can be replicated by machines, and therefore there will be an opportunity for the machines to be operating and therefore replacing psychologists, not just augmenting them. I think there had been a sea change in the way which machines, which are predicated upon learning, the algorithms which learn from first principles, can't, in a very short period of time, replace the functions that they had thought to be able to be simulating on mimicking, and therefore I think in the next 10 years we have to look to a very, very significant change in the world we have for how artificial intelligence will have an impact upon employment, especially in the professions, and you can always look to the past.

It was, I think, on the radio this morning about we've replaced agricultural workers with industrial workers, and, therefore, there will be another phase of creative workers who replace the industrial workers, but the evidence for the artificial intelligence literature now is once we move from an idea that you could simulate how humans think to a machine which puts into place a different system of thinking, then we have changed the whole part of that, and that's the problem that I see and we see emerging in the employment of psychology. It's a good – sorry, Commissioner. It may be a good thing in that it's going to replace a lot of treatment of mental illness, but it will be at the expense of psychologists and not simply at the augmentation of psychologists.

MS ABRAMSON: We've seen it in financial services, like artificial intelligence in terms of financial plans and things like that, but, I mean, correct me if I'm wrong because I may have misunderstood, but that runs to algorithms that are quite good at predicting the type of financial products that someone might want or might need, but people are so – I mean, I feel embarrassed talking to a room of psychologists, et cetera. But people are very complex, so how is it that you would be able to have the machine learning that would be able to replicate the things that a psychologist might do?

PROF INNES: Well, if I can explain the reason I got into this particular realm of thought was because I saw some of the data which came out from Oxford and from KPMG and all those kind of worlds that said quite simply that there is a threat to general employment, but it's all right, psychologists have got a .005 per cent chance of being replaced by mods. But when you go into their algorithms they assume certain things that psychologists do that can only be done by empathic psychologists, but an awful lot of things that psychologists do are reviewing the literature, looking at the evidence base.

I heard previous speakers talk about the evidence base and all the things that are available. Machines can access that literature far more efficiently than any of us in this room can do. Machines can carry out the assessment and the diagnosis of conditions more reliably. We've known for 60 years that algorithms are better at diagnosis and assessment than human psychologists. These processes are being replaced and are replaceable by the machines, and so there's going – I listed four pillars: assessment, formulation, intervention and evaluation, and at least assessment and intervention and evaluation can all be done by machines more reliably than a psychologist.

MS ABRAMSON: But, you know, it could be a thing that's positive too because one of the things the Commission has been struggling with is getting services to people in rural and regional Australia. So leaving aside the quite complex and difficult issues, we can't get some people to use services online. I mean, that's the first challenge for the Commission. But it could actually be something as it develops that's a really good way of getting services to people.

PROF INNES: Undoubtedly. But if services are produced for rural and regional Australia and can be shown to be superior to what has been done, then bracket creep will be introduced to people who are living in other areas of urban Australia because it will be deliverable. And a lot of people do prefer interacting with machines rather than with

humans who tend very often to evaluate you and raise their eyebrows when you say certain things. I mean, machines can be more abstract, can be more impersonal, and that is an advantage (indistinct)

PROF KING: More anonymous.

PROF INNES: Sorry?

PROF KING: And more anonymous (indistinct).

MS ABRAMSON: I'm terrible. I keep thinking of the computer in 2001, HAL. Do you know what I mean?

PROF KING: HAL, yes.

MS ABRAMSON: Yes.

PROF KING: You can't do that.

MS ABRAMSON: You can't do that, yes.

PROF INNES: (indistinct) but it's – yes. And those are the models that we have in our head about how machines can do what they can do, and your point is taken, Commissioner. There will be an advantage for services and resources in the next few years, but if we do not really formulate this and face up to it, then the workforce will be hit by a tsunami of change when we're not prepared for it, and we think we need to be factoring into projections for the workforce and for the treatment of people from that workforce with the possibility that there's going to be a change in the way in which we train psychologists, employ psychologists and have a view to the nature of the workforce's cycle.

MS ABRAMSON: Look, it's a really interesting submission. To be frank, it's not something that we would have turned our minds to, but, given that we see so much change in other professions, there's no reason to think that there wouldn't be change in psychology.

PROF KING: No. But I would say as somebody who's a techno-optimist and I was massively out on my predictions of self-driving cars and I'm not (indistinct).

MS ABRAMSON: You and everyone else, I think.

PROF KING: Yes. But the problems have just been much harder because, damn, humans are unpredictable.

PROF INNES: And I think - - -

PROF KING: So I think your main point is - - -

MS ABRAMSON: I think it's very interesting.

PROF KING: - - - that there's a change, and the profession has to be aware of the change in the chain, but I think we've got time.

PROF INNES: Yes, we have time, but it's a shrinking window.

PROF KING: I understand.

PROF INNES: And I think the legal profession is finding the same kind of pressures in the ways in which a lot of the work is done by lawyers is being overtaken by machine learning.

MS ABRAMSON: A huge amount. Probably at the risk of too much information for this inquiry, as a junior lawyer we were forced to go through all the documents for discovery, and now machines are doing it. Yes, absolutely.

PROF KING: And you've just stolen my end joke where I was going to put out that the psychologists would be out of work and they would join all the lawyers. So thank you very much.

MS ABRAMSON: The lawyers find other things to do. Thank you.

PROF KING: Fortunately, economists are completely unpredictable and relatively random which machine learning will never be able to – I'm not sure I should say things like that. But next person, Karl - - -

MS ABRAMSON: Well, I don't know. Paul Rose has got you on the transcript.

PROF KING: It's on the transcript too. Karl Brettig, please.

MR BRETTIG: Yes. The psychologists would be having to deal with the same issue as the print media. They thought they had plenty of time too, but journalists now are in disarray.

PROF KING: Print media has been extraordinarily slow to adapt, and my take on print media is that – sorry. You're getting me on to a hobby horse.

MR BRETTIG: You've got to remember - - -

MS ABRAMSON: And you will be getting off the schedule for the time. I will have the whip out again.

PROF KING: Sorry. Before joining the PC I was an academic. The area of economics that I worked on was competition economics and mainly areas like digital platforms and so on, so, unfortunately, you've got me on my hobby horse. Please state your name, affiliation, who you're representing and any opening comments, and I will be quiet.

MR BRETTIG: Yes. My name is Karl Brettig. I'm the manager of Salisbury Communities for Children which is based at the Salvation Army at Ingle Farm. You have a submission from the Salvation Army.

MS ABRAMSON: Yes.

MR BRETTIG: Which covers employment and homelessness and children, but I will be speaking to the children aspect of that.

MS ABRAMSON: And I understand, Mr Brettig, that you wanted – as a supplementary to your submission you had a video presentation which you're able to send through to us.

MR BRETTIG: Yes. That was in the context of 15 years of Communities for Children people still don't really understand what it is, and so we developed a video which actually explains it, but probably before I will have to explain something about it because probably not too many of you are very familiar with - - -

PROF KING: Just briefly. Sorry.

MR BRETTIG: Well, it's funded by the Department of Social Services. It started about 15 years ago, and there are 52 sites throughout Australia, and each site is a cluster of suburbs, and in each of those sites there are areas where there are low socioeconomic conditions, and the model operates through designating a facilitating partner in each area to bring together services to support families, initially with 0 to 5, and then 0 to 12 children. So, that was established in 2005. I noticed in the draft report, I think on page 656, it talks about getting families support around children in the early years, and it says that the services are largely fragmented, and not coordinated and are often not getting to the people who most need them, which is a good observation.

And I guess, to put it simply, communities of children is a model which the Federal Government put forward to try and deal with that issue, and bring together a structure which will enable people to come together as a representative group from the community, and work out a strategic plan to address the issues within a community. So that's going to be different in each community, but that model has been in existence now for 15 years, and now we're seeing collective impact, I guess, as the model that's being looked at, but there are lots of parallels between what the community children model has been doing for 15 years, and there are lots of learnings that we've had in that time, so it's been a fantastic opportunity to look at how we can actually work together better in local areas.

So, it's really an early intervention and prevention model approach. So in some ways it's outside of the scope (indistinct) Commission. As we talked about earlier, with the social

(indistinct) of health not being included as part of what we're about, but we live in a complex system, and it's probably good to talk a little bit about what we can do in terms of early intervention and prevention in the mental health area. In our experience, we discovered that there are probably two windows of opportunity that you get, and the economics of it are such that, you know, well (indistinct) talks about a ten-fold return on investment in the first 1,000 days, the early years. We talk about the first 1,000 days.

So if we can put as much support around families in the first thousand days, as we can, we will get a really significant return on investment, in terms of what we will save down the track in terms of mental health issues, drug and alcohol issues, homelessness issues and all of the other cast of issues that we get. The other opportunity is through junior primary school, which is the second window of opportunity, which probably doesn't bring the same amount of return on investment as investing in the first 1,000 days but it is significant, and so I will try to talk to both of those in a bit, and we can talk. I'd be really keen to hear your questions.

What we've done, we found that in terms of wrapping support families in the early years, post-natal depression screening initiative with the government is already good, and we found initially we got a lot of referrals from that. And when we did our consultation with the community, we found that people were really looking for a one-stop shop. They were looking for a place where they could go and not have to be referred from one place to another, but they could get significant number of services and supports in the single space. In South Australia, we have (indistinct), I think, in residence who was talking a lot about how we could do that, and in South Australia and a number of other states, children's centres have been established, children's centres for parenting and early childhood support.

And so, in our context, at Ingle Farm, we found a space in a school, and – which was the equivalent of about 10 class rooms – and we set up a space where families could come, and then get support. And we, in the process, through our committee, we brought together a government, non-government, education, health services, and we sat them around a table and we worked out how we could create, really, a community of support around families and children who were at risk of adverse social outcomes.

And the primary issue, I suppose, that we've discovered, is – is really critical in terms of early intervention, prevention, is really the issue of attachment. So, post-natal depression screening identified a lot of people who were at risk of having poor attachment issues, and there are numbers of initiatives developed around that, we developed one called Being with Baby, which provides support for mums, particularly, and so it's – within the context of a family setting, where the babies can be looked after, while the mum's are able to be free to engage in group process for about 10 weeks, and we have a (indistinct) redeveloped. So they often get the kind of psychosocial supports that they really need, and build healthy attachment. And then following on from that, we can then link families into – there's a parenting course called Circle of Security, which builds attachment, and we've developed other parenting courses then following on from that, once we (indistinct) together.

So, in a crisis, people – we have found, for example, people will come to the school and maybe have had a domestic violence event over the weekend, and they'll come to the school, and the principal will then be able to take them into the family centre, and say – you know, schools just do not have the capacity to respond in the (indistinct) kind of a way, to that sort of situation. But within the context of the family centre, or a children's centre – or a child and family centre, sometimes they're called – there are differences between them, but there are also parallels. So they can get wraparound services and support, and they can be linked in to other supports. It really is developing a village around the child, community around the child is the concept.

And having the option to do that has been fantastic, and we've been able to measure it in terms of population health outcomes, in terms of the AEDC we saw a - Australian Early Development Census – we saw a reduction in vulnerability of 10.4 per cent between 2009 and 2012. We started in 2006, so that (indistinct) would have been picked up by the AEDC in 2012. It obviously wouldn't have been picked up in 2009, but we saw – yes, about 10 per cent improvement in vulnerability. And we can say with some confidence that that related to the Communities for Children project, because we had – we were part of a national evaluation, and we had baseline data when we started, so we knew which services were added during that period. And when that cohort got to, in 2015, the NAPLAN, again there was a really significant improvement at Ingle Farm in terms of the literacy and numeracy outcomes for those students. And also, we saw a reduction and substantial (indistinct) of child abuse in the area.

The other concept is the world being a classroom. We initially were working with children 0 to 5, and then we go to work with children 5 to 12, as well. And so we got to – and of course, those children are in schools. We looked at what was actually happening in terms of social/emotional learning, within the context of schools, and we found that there were already a lot of social learning programs starting out, starting to be part of the school curriculum, but we found there wasn't a lot in terms of emotional learning, so we looked around and we discovered a program called Kimochis, which is basically built around teaching children to identify feelings, and have a feeling vocabulary.

MS ABRAMSON: Sorry, what was the name of that program?

MR BRETTIG: Kimochis. It was developed in – it's a Japanese word, but it's developed in America by a person called Ellen Pritchard Dodge and others. And so we found that we were able to teach children about – to identify their feelings, and also it includes personality types as well, so they can – various doll – well, they're characters who are dolls, or play things, you know?

MS ABRAMSON: Yes.

MR BRETTIG: Things you can play with. And so they get a better understanding of different personalities, and why people are different minded, and it helps them in conflict resolution and understanding and all that sorts of things. And also we obviously learned a

lot about trauma informed practice, and trauma informed – and trauma responsive practice; how to respond to children that have been traumatised at home. I started out as a teacher many, many years ago, and, you know, I had no idea what these children were experiencing in their homes before they came to school and why they couldn't learn because they were, you know, really, really traumatised. So we developed a concept which mentors people within the school, teachers within the school to be able to learn about trauma-informed and -responsive practice and be able to relate differently and change the whole culture. We started calling it the wellbeing classroom. It's now moved into a whole of school approach. So it's really changing culture, the whole culture of schools, and we're just in the process of finishing.

We did an evaluation initially at a school, and it showed that there was, you know, an improvement in feelings, vocabulary and in the child's sociometric data show that the behaviour was changing as well, and now we've just had another evaluation which – a draft report. We've got some of those reports here if you want to see those – which has over a whole school and three years we've seen bullying reduced by about – I think I've got the exact figures here somewhere. Well, the numbers of bullying issues reported in 2016 were 43, and the number recorded in 2018 was 22. So it's been kind of a decrease in bullying. And school attendance also increased from 89.6 per cent in 2016 to 91.8 per cent in 2018.

That might not seem a large figure, but when you consider we're probably dealing with a small population who have really complex issues it probably is significant. And also the other thing that we've seen is that it's a lot about leadership. It's about school leadership. It's about staff leadership, but it's also about student leadership. And within the school context we have seen the development of students as wellbeing leaders, and they came up with the idea that they wanted to be wellbeing leaders within the school.

They would call themselves wellbeing agents. They would meet fortnightly, and they would talk about the issues within the school, and they talked about how they can respond as peers with other students who are struggling with issues, and they were even invited by the school to speak at the staff meeting about how the staff were doing in terms of implementing wellbeing in the school which was a fantastic experience for the staff as well as for the students.

So both of those windows of opportunity for early intervention and prevention are significant, and I guess I would – we would see that it's really important that in terms of investing in the early years, that to keep developing that approach which will save, you know, mega dollars down the track – we continue to work at trying to get government to understand the significance of that and to develop it and to fund it because – and also that funding, I guess, because it's about developing communities, we really need non-government agencies working with government to develop those communities and see a significant change within our society.

MS ABRAMSON: Thank you.

PROF KING: Thank you. Just one then from me. So the intervention program for family support – so you’ve got a reduction in vulnerability population of 10 per cent. Again, this comes back to Dr Raven’s discussion that we had earlier today. And I understand the issues of attachment and attachment therapy, but the program can’t address the underlying issues – no. I’m making an assumption. Does the program go further and address the underlying issues that may be facing families?

So you mentioned domestic violence. The program, presumably – can it address things like the causes and consequences of – it can address some of the consequences. Can it address the causes of domestic violence? So if you have the intervention at the family level, you know, but it’s driven by poverty or by poor housing or by unemployment, to what degree do you hit a barrier, I guess, with those things?

MR BRETTIG: Well, obviously, the big concern with domestic violence is the cortisol released in the brain and the brain wiring that happens within baby, and – to give an example of somebody who has been through domestic violence on the weekend will present at school and talk to school counsellor or the wellbeing person in the school and say – and the school will have some capacity to respond to that, but if you have – it’s a family-centred concept.

PROF KING: Yes.

MR BRETTIG: In Ingle Farm the principles are we will take that person down to the family centre, and they are structured in such a way that they’re able to, you know, gather around that person for the amount of time that they need, and some of those people will need to come back to that centre, you know, three days in that week. Some others will come three days in a year because the issues are not so complex and so urgent.

So in that sense then you are able to work with the person and then refer to the appropriate services and so forth. I should also say, I guess, within the context of such a centre you have psychologists coming in who want to work with the whole community, so therefore we’re working with mental health people within that whole community. We’ve also made some strong connection with Child and Adolescent Mental Health Services, and we actually want – in one situation we have got Child and Adolescent Mental Health Services people coming into the centre one day a week, and we want to see more of that happening in other centres.

PROF KING: But let’s say the underlying issue – say inadequate housing or crowded housing, are you able to address that? Are you able to link in housing services or anything like that, or is there a boundary there?

MR BRETTIG: Yes, you are. And do it in a way – I guess the problem for a lot of people who have been traumatised is they just keep getting retraumatised by the services, and so if you are able to give a person significant time to talk about their issues and then be able to work with them and connect with the housing support that they might need, yes, you are able to do that if you have people – in a sense, you know, we talk about real

general practice service. If you have general practitioners, practitioners working – or family support practitioners, let's say, they have skills, and they are able to make those referrals, and within the context of a team if you have at least three or four or five professionals in centre, you have the capacity to be able to make those warm referrals so that they do get the support they need.

PROF KING: Thank you.

MS ABRAMSON: No. Thank you very much.

MR BRETTIG: Some of that documentation is in some of these documents.

PROF KING: Well, if Lawson is able to have a bit of chat to you because you said you also had some drafts.

MR BRETTIG: Yes. Okay.

PROF KING: So, Lawson, if you can – next we have Brad Morton.

MS ABRAMSON: Hello again, Brad.

MR MORGAN: How are you?

MS ABRAMSON: It has been over 12 months.

MR MORGAN: Really? It feels like (indistinct) you guys.

PROF KING: And if you can state your name, organisation you're representing and any opening remarks.

MR MORGAN: No worries. My name is Brad Morgan, and I'm from Emerging Minds which is a national organisation based here in Adelaide, and our focus and dedication is really focusing on the mental health of infants, children, adolescents and parents and families. From an organisational perspective, from the outset, the beginning of the organisation, the intent was to bring together in a single organisation family members with lived experience and professionals who engage in working with children, adolescents, parents and families, alongside researchers and policy makers. And the real goal for us as a national organisation is to work together with these groups to identify policy workforce practices and interventions to better meet the needs of infants, children, adolescents and families.

So some of our major work that we've undertaken and one of the big pieces of work is we're funded at the moment by the Commonwealth Department of Health to implement a National Workforce Centre for Child Mental Health, so it's just a fairly new program, and that's in parallel to the Be You program by Beyond Blue which is focused on education and care settings. We're focused really on health and social services, and probably how I

would frame it is the home and community environment and context in which children live outside of the school setting. That's probably the best way – I guess where we put our energy and effort and work alongside that program. Other pieces of work that have been fairly significant for us has been the National Children of Parents with a Mental Illness initiative. So we led the development and implementation of that from late 90s through to 2017, which has since been transitioning into the workforce centred program, as well.

So, just some general comments, just congratulations of the draft report, and we're very pleased to see quite explicit attention to the needs of children, ranging from early childhood to adolescence, but in particular the needs of infants, toddlers and children under 12 in relation to the recommendations. We've put in, obviously, a submission, but also responded to the draft, which is late. Put it through, but really today I wanted to put emphasis on a couple of areas which I think there has been some attention paid to, and other hearings, but just specifically a couple of items, rather than everything that as in the report or in our submissions as well.

So, the commenting I'll be looking at is really looking at reports of us developing integrating and expanded system of support for early childhood mental health, and primary school aged children mental health. And that really – looking at our system is looking at children at risk of, or experiencing mental health difficulties themselves. And the other area of work is really just in commentary around supports, and the recommendation around children of parents with mental illness as well, so just some reflections on what we have experienced so far, and maybe some ideas moving forward for that as well.

MS ABRAMSON: Can I also put on your list; we're interested, of course, in your views on the early childhood test, emotional and social wellbeing that we recommended.

MR MORGAN: Yes, I could do some comments on that as well, and then I'm going to a workshop in a couple of weeks on that, as well. I think I'll start off just talking about expanding systems of support, so that idea of children who do have prior experience in (indistinct) at risk of mental health difficulties themselves. So, as you'd be aware, there have been a number of investments made in those sorts of (indistinct), across health, across social services, across education, across Commonwealth, across state governments.

MS ABRAMSON: Yes.

MR MORGAN: And I think the common thing, I guess, from a national perspective was we know that many of them are working well, but there are sort of some bigger picture issues, I guess, which you've unpacked across those that are reflected in broader issues around our health system as well, and I think overall that's reflected alongside some commentary around social (indistinct) of health, which play an important role across adults, but also the children of those adults who are exposed to the similar sort of levels of, I guess, poverty and socioeconomic inequality which contributes to that, which I won't comment on today, I think there's been commentary on that. But I think, probably,

in relation to servant systems, I guess what we are particularly concerned about is, really, that miss-match between population need and actual services, and I think the cascading effects of that across a whole range of service systems, particularly in childhood and adult services as well.

I guess when we think about a cascading effect, I guess the analogy, or the examples of that would be (indistinct) for example, are the (indistinct). In relation to, I guess, we've got sort of that evidence only, less than 50 per cent of children who would meet the pointy end thresholds of diagnosis, for example, get access to any treatment or adequate treatment that would address the need of that pointy end, and so what we notice with services from spoken between them is, the consequence of that is the services that might not be funded to those services are seeing those children, and aren't able to offer that level of comprehensive, integrated support that brings together health, education or other services that need to be brought into that system.

So, a consequence of that is that we're not offering, I guess, offering an adequate support to make a change to a lot of children's mental health, and some just aren't accessing any of that support, as well. And I think that comes back to some of the commentary around – there's an issue around identification, which is one small component, but I think what we also hear is those that do identify the issue don't have anywhere to go with that, which probably comes back to some of this, I think, to work through which we talk about the social and emotional wellbeing check.

MS ABRAMSON: Yes.

MR MORGAN: The other issue, obviously, that comes alongside of that is the size and capacity of trauma in the adolescent mental health workforce in general. I know there was some recommendation around child and adults in psychiatry, but I guess there's also other workforce groups, including allied health and peer workforce, as well. And I think, probably, even in the context of peer workforce, I don't think there's been much attention paid to that in general, around what role and opportunities there are in the – outside of the adult sector, or potentially they'll integrate some of that, sort of, work too, then, though around impacts on parents, families and children in the one place. So that's an opportunity which we've commented on.

And then I think the other commentary in our exploration with some of the (indistinct) and mental health professionals out there is because of the thresholds and lack of resourcing in those services, often infant, child and (indistinct) are bundled together as prioritisation naturally goes to those that are the most (indistinct) presentations, and they tend to be in adolescents. And the consequences of that is, children who are quite severe don't get any support, because they're not going to be the same level, I guess, in risk in the context of that severity in adolescents. But also within that is the workforce who's in that specialist group, I guess you'd want them to be specialist in infant, child and adolescent mental health, is they sort of feel like they're being deskilled, or don't have the skills to work with children under 12, because they don't get the opportunity to actually

see them at that point again. So it's a very challenging area of work that needs, I guess, to address some of those overarching issues of lack of access.

And I think within that, I guess, we see it as an opportunity, that it's going to take a while for us to build a workforce in this area, it needs to be part of that broader workforce strategy, based on some of that population health guard that we know there is. It's also an opportunity to think about where is the best place to address those needs, and who else can be brought into that space. I think we've had a system that's been quite driven around psychiatry, allied health and nursing. There are other opportunities to bring in other allied health professionals, but also peer workforce and some of the social services in that area of work.

So I think that's the one area, I guess, that we, sort of, concerned about. But I think the other, underlying concern we've also identified is a really low level of child mental health which we're seeing in the community, more broadly, but also in the professions, including mental health professions around what actually is it. So, some of the challenges we've heard is when we – and we've done some actual research and exploration into this, is when we actually think about mental health, people automatically jump into mental illness, and mental health conditions. And so (indistinct) the discussions we keep having about supporting mental; health tend to be very oriented around identification of conditions as opposed to opportunities to nurture and support good mental health.

And conversations in the media and in the community, I think, that have been had in the past, tend to apply explanatory models of adult mental illness onto children, and the consequences you're aware of, where things can't be pressed in relation to this area of work. And I think, just in general, what that sort of flow-on of low child mental health literacy is obviously a community lack of commitment to this sort of area of work, and then when we do book commitment in, it tends to be oriented about they pointy end, as opposed to the investments of prevention and intervention. We also don't know what's the difference, and that's just what's the difference between normal developmental challenges and things that families go through, versus what actually do we need to pay attention to, and how do we help that to happen, and I think alongside of that is also knowing about vulnerability and the types of experiences that increase vulnerability but not yet present as challenges, emotionally behaviour yet.

So, in early childhood, we know things such as exposure to adverse childhood experiences, and accumulation over time results in, sometimes, presentations, so these difficulties coming out in psychological distress. But that might not appear in an infant yet. It might, but it might show up in late childhood, or it might show up in adulthood. And so, it's accumulation over time of those experiences, and so I think for a lot of the investments and practices that we're looking at, there isn't a magic fit, I guess. It's sort of looking at practices that really hone in on daily lived experiences, of children in the context of which they live and learn, and what are the practices that might change that, or buffer against the impacts of some of those challenges.

So I think some of the areas of opportunity we see, and this is just on a couple of examples, is, I guess, expanding a bit more of a focus on the opportunity, particularly in primary care settings, around integrated systems of support for children. We notice, sort of, quite a lot of attention on education settings, which are an important place for support. We also recognise there's inherent challenges and risks in that space, as well, and that sometimes the aim is bigger health – mentally healthy education settings and support good mental health, but we also know that is not experienced by all children, and that means they can also be a source of discrimination and exclusion as well. So, overall there needs to be that sort of lens on the education system that's important, and extremely important, but not the only place for us to be offering support.

General practitioners – I know we had some commentary before – we do perceive them as playing a really important role. They're a uniquely placed profession that operates across the lifespan. They're the ones that are exposed to knowledge about what's happening with family more broadly, so connecting the dots between what might be happening for the adult and then thinking about what's happening for the children in that context or vice versa.

So I think in general we would see opportunities to expand their role and support that role, and that needs to be multi-layered. I think as Caroline was saying earlier around that role includes assessment skills and training development which we're working on through our program, but alongside of that is incentives in many forms to wrap around and support that work to happen, but also is bringing into that space some of those services and opportunities that haven't been probably as well utilised.

We've obviously got programs like psychological strategies in that internet system, but there's also a question that needs to bring in some of those social services or adult services into that space, and so some of the work we've been exploring, and there's examples in Australia but also internationally is an idea of medical home and paediatric medical homes which, in America, is all around paediatricians, but the primary care provider in Australia tends to be general practitioners, so building up some of that paediatric skill level in general practitioners as a primary entry point which families rely on and trust a lot of the time to respond to that. So there's some opportunities there.

But alongside of that, the GP's is, when they're identifying or exploring, there's issues they describe nowhere to go, so particularly for the under-12s we talk about - I think we've got examples of where they had - children in very severe distress, but no one will see them, and so they're just sitting and holding and have to wait until they're an adolescent simply until those presentations are so severe that they can activate a system around them and they don't have the confidence to manage those issues and can't get supports.

MS ABRAMSON: Or worse, some of them are in the justice system.

MR MORGAN: Exactly. Yes, so I think there's an opportunity, I guess, to emphasise the role in more of that setting.

MS ABRAMSON: Yes.

MR MORGAN: Or those settings in that report we could do a bit more and set up some systems in parallel to some of those other recommendations in schools, and even the connection between those as well.

Another area we wish to comment on was recognition of the need to support children of parents with a mental illness. So as I mentioned before, there was a national initiative which ran from the late 90s through to 2017, as in transition did to this program, most of the elements of it, and that work has worked quite collaboratively with a whole range of international initiatives that are trying to progress a similar lens, I guess that idea of a two-generation focussed approach, or even more, around how do we address and parallel the needs of the adult who's a parent, alongside the needs of the children.

And in Australia we've had that work complemented with a range of state-government funded initiatives as well, not in every state, but for example in Victoria there's a families of parents with mental illness strategy; New South Wales a (indistinct) strategy which is soon becoming a family-focussed strategy, and Queensland and WA have had different sort of, probably not as well-resourced opportunities but some systems of that.

But generally I guess in relation to practices interventions that are being used internationally, locally, I guess characteristics of those is a recognition of the diversity of that and the size of that population we're talking about, so in Australia we're talking about over a million children who have a parent or live with a parent in any 12 months where there's a parent with mental illness.

And I think the message we sort of unpacked around that is that their needs are so diverse. There's children that are thriving, there's children who are vulnerable and there's children who are in contact with child and adolescent mental health services, child protection systems and so I guess, you know, the message behind all of that is, there's not a magic fit or program that's going to work for that population. They're as diverse as anyone in the community.

So the characteristics, I guess, of the interventions that have been implemented internationally, but also locally, are those that aim to contextualise both and understand the strengths and the vulnerabilities in the child's daily life and context.

So models that we've sort of been looking at is, it takes into account strengths, and knowing that there are process that - there's a lot of families have lots of difficulties and that's, I guess, more normal than not, to be honest, where you're looking at strengths of the family and networks around the family have activated to support children to remain or be able to respond to that.

So, and then I think intervention is sort of a parallel to that. The ones that seem to have the best evidence are those that aim to identify those strengths in the networks that wrap

around the family and deliberately pay attention to how do we keep them there when things might get bad, but also parallel paying attention to some of those vulnerabilities that are present as well and how to reactivate networks of support whether they're informal or formal for the family and the children.

As I said, the two-generation approach also is a very strong feature of those practices, that they can't separate individual adult recovery from children's needs.

PROF KING: Yes.

MR MORGAN: And at the moment we have a system that does, so as an adult, and we spoke to lots of parents when they enter into adult mental health service. It's a surprise to them, or many of them, that they're not even asked about their family or their children or their parenting and that's not brought into it, and for others they've had a really negative experience where their past is that their children have been removed or they've been judged negatively. So getting a balance in that space of creating a context, a conversation that enables that strength-based focus, but also we can address some of these vulnerabilities here as well and activate the supports that are needed.

And then in general the processes, I guess, of these interventions that have good evidence, it's underlying that as they aim to strengthen processes of family problem-solving and linking indication which assists in problem-solving. So when we're looking at those interventions it's recognising that we're not going to get a magic recovery from mental illness in a parent.

Recovery takes time and it means different things for different people, and so the idea is how do we deliver processes that enable problem-solving to address the challenges and the changing challenges that families have, but building capacity within that family to activate the networks or facilitate processes. So that's what the evidence around interventions are.

And then alongside of that is exclusive attention to relation or how to solve mental illness and mental health needs in the family, and parenting roles and those sorts of things. They aren't exclusively addressed in, for example, our mental health service will address and talk about employment, and talk about participation inclusion, but it's very rare that a conversation around how is a family going, how is the treatments impacting on how you feel about getting up in the morning and getting school kids to school, those sorts of things.

They aren't routine. We've got resources that can help that to be routine, but it's not an expectation of services to do that, so for some families they talk about having a really good experience of that being part of their recovery, but others say, 'No, well, it wasn't even raised and discussed and we actually had really negative experiences of it'. So I think that represents, I guess, what we struggle with, a system nationally trying to operationalise some of these interventions and practices and programs is - they're

unfortunately driven by local champions who lead with passion, but it's not an expectation of services that they provide these types of services.

MS ABRAMSON: In fact, it's interesting on the relational point. We did receive quite strong criticism that we hadn't actually covered the relational aspect of mental illness, and our answer to that was, well, it was actually in the carer's chapter, so it was actually, we had dealt with it quite explicitly.

MR MORGAN: Yes.

MS ABRAMSON: But, you know, we did take that on board, that people said, 'But in your earlier part you hadn't actually talked about it'.

MR MORGAN: Yes. Yes. And I think that's part of the challenge, I guess, we've flagged overall, is around how we describe people in relation to the mental health system packages.

MS ABRAMSON: Yes. Well, we struggled at - - -

MR MORGAN: And we have carers and it's a really - unfortunately it's almost in the context of you are either/or.

MS ABRAMSON: Yes.

MR MORGAN: But also a child isn't a carer. They are a recipient of care of the consumer potentially if you want to frame it in that type of language, and vice versa, that what we hear from a lot of parents who might be labelled as a consumer, and also a carer of a child who has a mental illness, a child of a parent with a mental illness, who I'm also managing.

MS ABRAMSON: M'mm.

MR MORGAN: So I think challenging this idea of consumer carer as the - not - they are important identities, I guess, in the definitions that we have, but we need more than that to reflect the reality of context and the roles and multiple roles that people play simultaneously that we are just recipients of care. We're also providers of care in lots of different ways and context in our relational roles and so I think that's where some of that challenge comes from, a lot of the way with model systems.

PROF KING: Can I follow up on the social and emotional wellbeing checks for, at the pre-school level. When you mention low level of literacy around child mental health, and putting in adult lens on to child issues, I mean, and you've seen the push back that we've received. You will be aware of earlier recommendations for these sort of checks that have been unsuccessful and been opposed, and you'll recognise the role. On day one we had unsavoury, in my opinion, headlines in the press which I mentioned earlier on.

How do we deal with that? Is it just a matter of literacy and understanding around social and emotional wellbeing for children, or - because I fear if it is just that then we've lost, you know.

MR MORGAN: I guess in my mind, I think there's a few strategies, I guess in mind. I think we've done some work looking at child mental health, especially with the frameworks (indistinct) America, and they sort of explored the nature and the order of the way you tell the story. About these types of issues that result in positive changes in community understanding of these types of issues, rather than decreasing, I think, is sometimes what you see.

So I think the example made in these two-stage studies and things - child protection, for example, where ads with good intention about child protection and not little children, for example, have actually decreased community political commitment and interest in that topic. They would have been better off not doing anything because the messaging that the community - went, this is hopeless. We can't do anything about it, and so what we do in that is we ignore it to some extent, and so I think similar risk could occur in relation to child mental health.

Because if we start from illness, we will hit the same problem. But also, alongside of that, I think that sort of risk like social and emotional wellbeing checks is - the nature of the check really needs to be framed, and I guess if I'm (indistinct) development.

MS ABRAMSON: Which is what we - - -

MR MORGAN: And that's what we've been trying, I know, and I think that will be important, I guess, a collective response from different professional associations and audiences, including family members to talk about - I won't actually be talking about here. One of the questions that we're asking, because I think we sort of get shrouded in this idea that we're going to be diagnosing children with all these issues, and I think within that is that sometimes that might be an important thing that we do need to attend to find some circumstances that this little child needs specialist intervention from the medical system around some of these issues.

MS ABRAMSON: Although interestingly, where we started from was about family support. So it's actually giving the parents, the caregivers, the tools they needed to assist the child.

MR MORGAN: And I think alongside of that is there are existing data sets that tell us quite a lot about children's mental health as well. And obviously, they're associations and they're not in a lot of the research, but if you look at the Australian Early Development Census, that was framed. There's been studies done in Canada, for example, where they track children over many years using a similar measure.

MS ABRAMSON: Yes.

MR MORGAN: And from the scores that are identified in early childhood or in the first year, around five, is that they can actually make estimates around which percentage of this population is likely to go on to experience these particular types of mental health difficulties. So we do have some of those measures that have potential to help us identify groups across that lifespan around there's going to be a likelihood that there's 20 per cent in this community that go on to experience depressive cognitive challenges, or this group's going to go well, or this - - -

PROF KING: Can I then tap on another point that you mentioned, which is you said when to intervene. But that's also been issue that's come up in comments on children. The claim, well, this sort of approach focusing on children means that you medicalise it, make clinical just normal life events.

MR MORGAN: Yes.,

PROF KING: And I understand there is a grey area of when is it just normal life events versus when is it something more than that. Again, how should we be thinking about this? Other than it's a grey area.

MR MORGAN: Yes. I think what we put forward in our original submission, which is sort expanding, is expanding our definitions of different population groups (indistinct). I think we've historically had a very linear, diagnostic pathway of prevention and early intervention support. So anxiety equals let's step back and look at prevention of anxiety, or an intervention for anxiety, or treatment for anxiety, rather than, I think what we're sort of encouraging, look at psychological stress and adversity as measures of treatment of mental health, and those continuums of those.

So in our submission, we sort of did a bit of a table list to say, well, we know that 50 per cent of children who are two to four years old are living in no adversity, and very low psychological distress. What they'll benefit from is overall sort of issues in schools and things that will support good mental health. But moving across that continuum, we also know there's children who are doing well, but are exposed to high levels of adversity and vulnerability in the family or community context who would benefit from prevention activities that might not specifically address the social and emotional elements of ending the actual issues, because they haven't got any yet, but are addressing some of those, I guess issues that are disrupting the family more generally and how we reduce the level of that disruption over time.

So hence, some of the practices from the - for example, that (indistinct) work would be useful in those areas. So selective prevention is how we describe it. So I think it's expanding conceptualisations to make sure we're paying attention to adversity. It's such an important determinant of children's mental health and that - we need to measure that alongside just psychological or symptoms that are preventing - because okay, they need equal attention.

So we framed it as one of the most expensive prevention interventions is intensive family

home visitation for parents who might be going through - they're really expensive. They're not cheap, but the intention is those longitudinal outcomes that come from those that have experienced 20 years down the track, or 40 years, are adjusted, or those sorts of things, and I think - I think for me is expanding - the Stepped Care Model is good, but it needs expansion to take into account adversity as another step in that work, which is what we're proposing.

Because at the moment, I think the Mental Health Commission Review, and in this one, I think, when we framed what's been framed as Stepped Care and the assumptions around the types of interventions offered, I think overall, based on a diagnostic model rather than integrating those two things. So when I think about prevention, I think what's listed on there is low intensity, self-directed supports as opposed to actually, in infancy it might be the most expensive intervention for children who are - infants who are experiencing challenges, yet that we know are likely to - so it's just, it's more the type of interventions I think that we activate and offer that need to take into account more than just the presenting symptoms.

I think that's sort of, I guess, what we would reflect, and I think some of the work that was done here locally, so - and that's what we referenced in our report. But I can send you some more information. It's just the modelling around how many children do fit into these different areas of work and who might benefit from this particular type to be a basis of, I guess the overall work or strategy. How many people do we need who could deliver it? All those sorts of things would be really good.

PROF KING: Okay. Thank you very much.

MS ABRAMSON: Thank you.

MR MORGAN: Thank you.

MS ABRAMSON: Well, I'll have a good read of your submissions. So thank you.

MR MORGAN: And like I said, I'm always happy to share more info. Thank you.

MS ABRAMSON: No, thank you very much.

PROF KING: And Lucy Trethewey.

MS ABRAMSON: This is the book that Lucy - - -

PROF KING: We've got the book.

MS ABRAMSON: Yes.

PROF KING: But Lucy - - -

MS ABRAMSON: Yes. No, that's her nom de plume.

PROF KING: Yes. And if you're able to state your name and if you were - if you are representing an organisation, what organisation that is.

MS TRETHEWEY: Hi, my name's Lucy Trethewey. Thanks for having me here today. I'm a children's author and I've worked in mental health as well.

MS ABRAMSON: Lucy, you might need to just speak up a bit because the microphones are not for amplification, they're just for the transcript.

MS TRETHEWEY: Thanks. Yes, thanks for having this opportunity to talk. Have you heard of the identified patient, the family scapegoat, the symptom bearer? Have you heard any of those terms? I'll just explain them briefly. So, an identified patient in a clinical term is one family member in a dysfunctional family that sometimes expresses the family's conflicts through their behaviour.

Sometimes it's very overt, sometimes it's covert, sometimes in boys it can look like ADHD or (indistinct). The behaviour in girls, they can be very quiet. That's from psychiatric. In family systems therapy, they call the symptom bearer, and the symptom bearer kid is the one that becomes the identified patient in the dysfunctional family, becomes the scapegoat. The family says this is the sick one in the family. A lot of people can't recognise it when it happens. Sorry, I got really - I got myself confused. I might just ad lib.

Yes, so it's a serious dysfunctional family system, and it seems very narrow and probably not - you probably can't see it in the big picture, but in the big picture, it actually affects a lot of things. Because a lot of scapegoat kids, symptom bearers, identified patients, are what fills up the mental health system.

PROF KING: Yes.

MS TRETHEWEY: And they also become a way for that family to pass on intergenerational violence, intergenerational addiction or violence, or just a personality disorder that gets passed down. It gets passed down through that family system. There's also, they say, the lost child, which is the child that might be trying to make themselves very small and quiet and avoid interactions with family members and basically disappears, becomes a loner or is very shy.

So I went looking – I worked in mental health and I picked up – because I knew some of the kids I looked after had grown up in families like that, the scapegoat kids. Pretty severe scapegoat kids. They ended up in the mental health system. I supported two, and the services identified them as the mentally ill one and the parents would come in and identify them as the mentally ill one as well when they were bullied at home and abused at home, or put down, or shamed, or mocked, or ostracised, or separated deliberately by their parents. It happens in wealthy families. It happens in all types of different families.

So sometimes those kids can end up diagnosed with a mental illness. I was kind of happy but then I spoke to some and they said it's not a good thing, either, that complex PTSD is going to be added as a diagnosis for children. Have you heard that? A new diagnosis or something, which might help people become more aware of this in kids?

MS ABRAMSON: We certainly – Stephen and I have not focused on the clinical side. We do have Harvey Whiteford, who is a psychiatrist. So Harvey might be aware of this, but.

MS TRETHEWEY: Yes. So I went looking to help a child who I'd seen getting bullied at home by two very high-functioning, educated – really presented nice parents, but they really picked on one kid and it's all very oppressive. No one can talk about that when it happens in a family. I don't think services are equipped to deal with it. So I went looking, went looking, asked people what to do. I mean, they do have a complex needs system which deals with that sort of dynamic, but the thing is, the parents would never admit to it and they won't attend that, and they would rather blame the kid, and so I wrote my book, *Scapegoat*, and then I had – it got changed when it went to the publisher. It got edited. I would write it differently, and everything to date, to me, is screaming we need the village to step up. We need the extended family to sit up. We need the aunties, the uncles, the grandparents, the cousins, the neighbours to step up to help kids, to prevent mental illness. We're very isolated at home with your parents. Family dynamics are so weird now that you can't get anyone to disrupt it.

PROF KING: Yes, whereas you'd expect that in the extended family there would be people there who would be aware of what's going on in the nuclear family, for want of a better word, and you would – you know, traditionally, you would expect them to step in, but they don't, now.

MS TRETHEWEY: Yes, and I think in the past – well, I don't know if it's always happened. But I think in the past people were more confident just to jokingly say something. 'Don't pick on her' or 'don't throw that at her' or 'don't be mean'. But we're really nervous now to pick it out, and I am too. I've actually been a part of this problem. I've joined in on picking on a kid, and I've seen it and I will do it as well because that's the dynamic of the family, and that kid will end up with a mental illness or will have – become a bully himself. There's a research paper I've read that children who are the siblings of severely scapegoated children have empathy deficiencies.

PROF KING: Okay, because I was actually about to ask that. So is – yes. Would it affect the other children as well? Because they're presumably joining in on the scapegoating activity. Presumably they're doing that because again, they're facing pressures from the parents.

MS TRETHEWEY: Yes, and they learn that they – that bullying behaviour, you hide it
- - -

PROF KING: It's acceptable.

MS TRETHEWEY: You accept it, you hide it, and that child, to survive, has to learn that that's okay, to survive, and that will repeat again, and this has consequences that are far-reaching and it's very learnt, highly covert behaviour, and I've seen it play out in weird ways in quite high-functioning educated people as well as lower-class socioeconomic. Bizarre situations. So I do think it affects - and it's relevant to this Commission as well.

MS ABRAMSON: Can I ask - bearing in mind you've been so patient because you've waited all day to give your evidence - what are the sort of things that you would like us to look at, Lucy? What are the things that from your perspective - because you've taken the trouble to come and make a submission to us, what would you like us to concentrate on?

MS TRETHEWEY: I think we need a message that the family and surrounding people have to stand up and government can't fix this. I'm sorry. It's almost - maybe government can help by funding awareness of these family systems and how they work, and that can be done in a pretty, nice, with a bow, 'look at my lovely book' or 'look at this lovely movie' and 'look at this child here' in a media type of way and then the people go, 'we do that at home, we didn't realise we did that', or the kid will actually think, 'that's what's happening to me at home. I didn't realise it wasn't my fault. I thought it was all my fault', or the other kid will realise, 'I never stand up for my brother'. I mean, like, you can portray it. You can portray it and show it.

I also think people are not educated or nuanced enough to pick up on it. Systems, mental health systems, even social workers, psychologists, child people - they don't mean to, but they will actually identify that child as the problem in the family and they will crunch down on that child and say, 'you're the mentally ill one, you're the one that's causing all the problems', whereas you need to take it right off that kid and say, 'this family is in this boat together and this kid is showing what's wrong in the family. We need to talk about that'. What else?

PROF KING: Yes, because it's - yes. What - so it is slightly different, but someone else in one of the earlier hearings gave evidence on - similar but different, if I can call it that, where one of the parents - often associated with a family that's in - dysfunctional and breaking down, one of the parents will use the children to gang up on the other parent, and again - and there's evidence there that that has negative effects - psychological effects on the children, obviously, who are being used by the one parent, and again - but how do you respond to that? Well, yes, there's no easy answer, and I guess it's exactly the same.

MS TRETHEWEY: You can tell kids that that's the triangle. You can describe it to children and they will - kids have the intelligence to pick up - kids have actually told me that and they will use children's language to describe it, and they're smarter than us. They will actually point it out and the parents will push them down and silence. The services will push them down and silence them. But the kids will say, 'we're communicating like a triangle'. 'Mummy tells me this about daddy, but no one will talk

to them and then they go through me.’ So kids are used to communicate passive aggressive - - -

PROF KING: Yes, behaviour.

MS TRETHEWEY: - - - perversely toxic hidden messages, but the kids need to be validated.

MS ABRAMSON: And what you’d like us to do is to think about that in the context - when we talk about children and the support for children, that there is this type of dynamic and we need to be aware of it.

MS TRETHEWEY: Yes.

MS ABRAMSON: Yes. I understand.

MS TRETHEWEY: Can I read the reference I got from someone?

PROF KING: Please, yes.

MS ABRAMSON: Absolutely.

MS TRETHEWEY: So this is from Ueli Kramer, the president elect of the European Society of Psychotherapy Research. He’s a psychiatrist. He says my book,

It may foster emotional awareness and help them to stand up for themselves. As such, it may contribute to tackle the effective roots of bullying and help prevent long-term mental health problems.

Yes, and I’ve got other ones here from psychiatrists, and what it’s trying to say is if a child is told ‘this is not your fault’, it changes the confusion in their brain and they might actually sit back and think, ‘it’s not my fault, I’ve been trapped in this family dynamic’, and you can do it in child-friendly language. You don’t have to do it in that kind of psychiatrist – you can do it in little animals.

PROF KING: In a sense, your book is doing that, yes.

MS TRETHEWEY: Yes, and that provides relief to a child’s brain because the child needs to know that it’s not a little kid’s fault that he’s been – you know, it’s not his – he doesn’t need to take that on board mentally, and he needs strategies to learn to survive that mentally because otherwise these kids will end up repeating it or mentally ill, and I’ve seen that happen.

PROF KING: Or they become traumatised.

MS TRETHERWEY: Yes. I've seen terrible things happen. So I would really wish, if anything comes out of this, that would be to stop that. Sorry.

MS ABRAMSON: No, I understand, and thank you very much - - -

PROF KING: No, thank you.

MS ABRAMSON: Thank you for the books as well. Thank you.

MS TRETHERWEY: Yes. So, the solution in my book is government interference and I got criticised for that.

PROF KING: Okay.

MS ABRAMSON: Thank you.

MS TRETHERWEY: Okay.

MS ABRAMSON: And thank you for being so patient.

MS TRETHERWEY: It's all right.

MS ABRAMSON: You've waited all day.

MS TRETHERWEY: Thanks.

MS ABRAMSON: Thank you.

PROF KING: Now, at the end of these hearings we always ask if there's anyone else on the floor who would like to put anything on record?

DR BENJAMIN: I got squeezed for time this morning so I wanted to add to my presentation.

MS ABRAMSON: Excuse me, I've got a 6 o'clock flight.

PROF KING: Yes. So, unfortunately, it's really just for people who haven't had a chance.

DR BENJAMIN: It would only take me about 30 seconds to say it.

MS ABRAMSON: Is it something that you want on the transcript?

DR BENJAMIN: Yes.

MS ABRAMSON: Okay. Well, we've got probably got – we've got a room booking issue but we've probably got about three minutes or so.

PROF KING: Can I check first if there's other people.

MS ABRAMSON: Is there anyone else that would like to speak?

UNIDENTIFIED SPEAKER: There was a couple of times today when you were asking for extra responses and I was just wondering whether or not there is an invitation at all to be able to respond to some of those questions in a written way?

PROF KING: Yes.

MS ABRAMSON: There is. There's an easy way for you to do it and Lawson is here. He's our staff member here today. But we have a comments section on our website and I think that would be the most effective way and you'll find it with the navigating to pc.gov.au, but Lawson, would you be kind enough to give some details?

LAWSON: Yes, you can come and see (indistinct words).

MS ABRAMSON: Thank you. But absolutely you can respond.

PROF KING: Okay. If you'd like to make any brief comment then on the record.

DR BENJAMIN: Sure. Do I need to go the microphone?

PROF KING: Yes, you'll need to for the transcript and you'll need to reintroduce yourself so that we can - - -

DR BENJAMIN: Tom Benjamin, Medical Consumers Association. Just adding to the end of what I was going to say this morning because of a rush for time. One of the big dangers that I see from the step-care model is going to be a possible depletion of the Lifeline counsellors.

MS ABRAMSON: Yes.

DR BENJAMIN: Because if they can't see a career path for counselling because they're squeezed out by the Medicare Benefits Scheme giving psychiatrists as much as \$220 an hour basis plus a gap fee, who else could compete with a business next door that has a \$220 government guarantee and can peddle drugs while other people are making maybe \$88 an hour and you're out there having to charge people out of their pocket. No business can handle that kind of competition.

Once these Lifeline counsellors, who are there to get their placement hours up; they're not there just because they want to give back to the community. That's the retired group. The young ones that are there are trying to get those thousands of hours of placement in.

When they find out that guys like me maybe closing down our practices, they will see the writing on the wall. Why would they keep going to Lifeline? If they have any sense they'll have to get a day job. They'll realise that counselling is not going to be the day job. They'll have to keep that waiting on tables job that they've got now. Thank you.

MS ABRAMSON: I understand. Thank you and thank you for being brief.

PROF KING: Right. I will now – sorry, there's some official words that I need to say.

MS ABRAMSON: Yes, adjourn the hearing.

PROF KING: Yes, where are we? Ladies and gentlemen, that concludes today's scheduled proceedings. I adjourn these proceedings. The Commission will resume hearings later this month in Darwin.

MS ABRAMSON: So, thank you very much.

PROF KING: Thank you very much for what has been a fairly long day.

ADJOURNED UNTIL MONDAY 24 FEBRUARY 2020



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

MENTAL HEALTH INQUIRY PUBLIC HEARING

PROF STEPHEN KING, COMMISSIONER
MS JULIE ABRAMSON, COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

AT MANTRA PANDANAS, 43 KNUCKEY STREET, DARWIN
ON MONDAY 24 FEBRUARY 2020

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PROF KING: Good morning, all. Welcome to the public hearings following the release of our draft report for the Productivity Commission’s inquiry into improving mental health in Australia. My name is Stephen King and I am one of the commissioners on this inquiry. My fellow commissioner here today with me is Julie Abramson.

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

The purpose of this round of hearings is to facilitate public scrutiny of the Commission’s work and receive comments and feedback on the draft report. This hearing in Darwin is one of many around Australia, in all States and Territories, in both capital cities and regional areas. We will then be working towards completing a final report to the Government in May, having considered all the evidence presented at the hearings and in submissions, as well as other informal discussions.

Participants and those who have registered their interest in the inquiry will automatically be advised of the final reports released by Government, which may be up to 25 Parliamentary sitting days after completion.

We like to conduct all hearings in a reasonably informal manner, but I would like to remind participants that there are key 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 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 the issues raised in other submissions. I also ask participants to ensure their remarks are not defamatory of other parties. You are all free to enter and exit the room as you want, and if anyone needs a quiet space, feel free to exit the hearing. If at any time you feel distressed, please approach one of our staff who will assist you.

In the unlikely event of an emergency requiring the evacuation of this building, the evacuation tone “woop, woop, woop” will sound. Please exit the building and make your way to the assembly point located at the post office car park.

Our first participant today is Bob Napier. Bob, would you like to come up to the table and just state your name and any – what you’re representing for the transcript.

MR NAPIER: I’m not familiar with the words.

PROF KING: (Indistinct) can be just for the transcript.

MS ABRAMSON: Yes, just have a seat.

PROF KING: Have a seat.

MR NAPIER: I'd like to show you a couple of photographs to accentuate a point.

PROF KING: Yes, that's fine.

MS ABRAMSON: Do you want them - - -

PROF KING: Do you want them put on the record?

MS ABRAMSON: Because it's hard for us, because we're on transcript, Bob, it's hard for us if we don't put them in - - -

MR NAPIER: Well, I'd like it back if I can.

MS ABRAMSON: Yes.

PROF KING: That's all right, yes, we can do that, that's good.

MS ABRAMSON: Absolutely. If you send them in an electronic form, we can put them up with the transcript or the submission, looking at our end.

PROF KING: Okay. Now, are you – because you need to be on there because you need to be on transcript. So I can show you which photo we're up to - - -

MR NAPIER: The first photograph is the Mandorah Jetty car park, I listed 20 things to the information – to the CEO of infrastructure, 20 faults on the next farm, and I'm not a qualified civil engineer. He replied he couldn't – it was all professionally done and there couldn't possibly have been any faults.

MS ABRAMSON: Bob, this is part of your submission later on, so do you want to start with an opening statement for us about what your big issues are, and then we'll get to this as you go through your evidence.

MR NAPIER: My major concern is – my focus is about bullying, I have three other small items, from personal experience, I'd like to present. One is, as a social phobic, there does not appear to be any representative of social phobia. The nearest we get is Rajesh on Big Bang Theory, where he's unable to speak to women, as I similarly was as a young man.

Three years ago, it took me several months to pluck up the courage to be able to say – to ask a lady whether she might care to join me for a cup of coffee. At age 65 – I feel uncomfortable just talking about this, it's - - -

PROF KING: Take your time.

MR NAPIER: But because there's no recognition of this, the mental health groups, GROW Group, that sort of thing, you can see these people, they sit alone in a corner, and that's as much support as they get. That's as much as I'd like to say on that.

PROF KING: Yes.

MR NAPIER: Second, an ad on TV, we need more finance for one-to-one counselling for victims of bullying. Now, that's good, but I would strongly recommend victims of bullying be given an opportunity for group therapy. Bullying by itself is very psychologically isolating, and therapy is comforting, but in a group, the brain realises that you're not alone, and it's the psychological isolation that pushes people to suicide, that type of thing. And that's as much on that.

PROF KING: Yes.

MR NAPIER: Having been seriously bullied, left Western Australia, I was prescribed Ristadol, tiny little white pills, take one at night. I cut them in half, took the small half, the next afternoon down at the small swimming hole in the mouth of the creek with my little boy, I'm thinking I could put me foot on him, hold him under water, drown him, go for a walk down to the water's edge, come back and say that I found him like it.

Now, at the time that did not spring out as being obscene, because I was thinking how I could invert the lifestyles of those who had been bullying on a similar plane. Two nights later I took the slightly larger half, woke up an hour later, cruelly busting for a pee, it was really cruel. Then for the next hour I got more and more wound up, agitated, with strong imposing thoughts of strangling my little boy. I promptly tipped them all down the toilet.

Six weeks later I seen an article from a Dr David Healy in Wales stating people on antidepressants committing suicide and murder-suicide. About 10 years later I got computer literate, I looked it up, I got a printout, 62-year old man prescribed Paxil for anxiety, within 48 hours he's killed his wife, his daughter, his granddaughter and himself.

This copy I showed my next door neighbour Jennifer, within about 10 days she was dead, she was on Paxil, classified as an accidental overdose. I feel there's sufficient information there that there should be a major inquiry into the association of suicide and antidepressants. That's crap.

PROF KING: Yes.

MR NAPIER: In 1983 my de facto committed suicide. In 1993, as a result of all these things happening, it occurred to me that I was being blamed, and in the next 10 years I got 10 references. The fifth was, "We were told not to employ you, you've murdered her and made it look like suicide", the 10th, about March 1985 was, "I've been told three times not to employ you", shire clerk, "Don't employ him, he killed his wife". Until I was – a fella in the post office and the previous postmaster of my ex (indistinct).

I spent \$30,000-odd on lawyers and a private investigator, he concluded that unless you have a family QC, they can pursue you, pursue this through to the High Court, and then the High Court of Appeal when they appeal against any decision, and access to a Maori bike gang rugby team on a sense of fair play, you were totally powerless.

I told the sergeant what had been going on, and he was quite horrified. I said any given Friday night you can grab the ringleader for drunken driver, but he'll lose his licence and the whole lot (indistinct). He said, no, I've done that, he'll get his cronies to write to the Commissioner and he'll be getting transferred to some antisocial town, and he wasn't going to do that to his wife.

So when a police sergeant of a small town is powerless, that is something to be aware of.

MS ABRAMSON: Bob, do you want to go back to what you think we should be thinking about in terms of bullying or like the top of communications.

MR NAPIER: I'm getting to that, that's my background. I got to Darwin, I was prescribed the pills, the first two psychiatrists diagnosed me as paranoid psychosis, two weeks later delusions of persecution. They couldn't understand what I was talking about, they didn't believe it because my story was so bizarre. It'll make a B grade movie strip. Eventually diagnosed post-traumatic stress.

Now, these days I go to uni, my focus is on boys, I'm doing counselling, and I can – society is illiterate to what bullies do. And I've got sufficient, I believe, information to validate that bullying is an addiction, commonly acquired at a young age, the insufficiently attached infant. Some become angry, some become anxious.

It fits in what you were saying about the childhood mental – from sight, hearing.

PROF KING: Early sources of – so just to tell us, so you'd say bullying itself, so bullying can cause obviously stress, tension, mental illness, but you would say also that the bully themselves, the bullying is a symptom of their own mental illness.

MR NAPIER: Yes. As any addiction, pretty much.

PROF KING: Yes.

MR NAPIER: Their need to feel validated or to hide so that they're – even anorexia is classified as an addiction, I believe from what I've read. I read a book – Tim Field wrote a book, *The Bully In Sight*, about his own personal experience in middle age, and many other people's experience, and all say the just utter futility, the system just does not acknowledge what's going on. Therefore, you're powerless.

MS ABRAMSON: Thinking about our inquiry, what would you like us to be thinking about in terms of recommendations? Because the way our report process works is that

we'll put recommendations to Government about certain actions that we think need to be taken. So what would you – given your experience and what you've been thinking about, what would you look to see us recommending? Thinking about early childhood, what would you - - -

MR NAPIER: That's a pigeonhole.

MS ABRAMSON: Or the workplace?

MR NAPIER: We classify an affliction across society, the workplace is just one pigeonhole. I read through the transcripts for – it was quite sickening, because some people did not fit the dimensions. So they can be bullied to the point of whatever, because they don't - - -

MS ABRAMSON: I guess getting back to what Stephen started with though, you'd be urging us to think about what resources should be available to help the person who's actually the bully, so to change their behaviours.

PROF KING: The victim and also the bully themselves.

MS ABRAMSON: Yes, that's right.

MR NAPIER: My perspective is biased. The victims come first, second and third, because the bullies operate like German raiders, but the system doesn't acknowledge it, and they just - - -

MS ABRAMSON: You made that point in your submission quite powerfully, because you talk about the experience that the person who was – that was alleged to have been doing the bullying, actually didn't leave the job, everybody else left the job. That's kind of the point that you made.

MR NAPIER: Yes. Because the system is illiterate to what's actually going on.

MS ABRAMSON: Do you know, Bob, different States have different approaches to this, so in Victoria – I'm a lawyer by training, so in Victoria we actually have some very specific legislation which deals with bullying, and it's called Brodie's Law after a particular case. And some of the other States have that type of legislation as well. So the consequences of bullying as well, or the treatment and support of both the victim and the person who's perpetrating the bullying, do you have a view?

MR NAPIER: My biased opinion is the bullies that made that car park, that car park was like what the Monty Python crew have done, they were effectively unemployable. They couldn't be trusted to clean toilets.

PROF KING: I suggest obtain a copy of the photo, which you'll later send through electronically. Did you want to – just on that, Bob, did you want to just run quickly through? So you've got other examples here. So sorry - - -

MR NAPIER: That's the approach road, it's a straight hundred kilometre an hour country road, to a blind dead end corner that dips beneath the horizon, with access through a drain that's just not visible until you're right there. And the bottom right-hand where there's been a couple of potentially nasty accidents. Is an example.

In the far right-hand corner you should see there's a no entry sign.

PROF KING: Yes.

MR NAPIER: And there's each way arrows, and the centre top you should see there's two give way signs, people doing 60 kilometres an hour from the left-hand side of that entry point have to give way to the people driving through the no entry sign. And it's been like that for nearly two years. So we have a whole community and a council that have failed to be able to deal with that.

MS ABRAMSON: So is the basic concern you have, Bob, that the infrastructure is not being constructed properly, given what it's supposed to be doing? Is that the heart of what your concern is?

PROF KING: Similarly the fourth one you've got is - - -

MR NAPIER: It says "Access above two metres".

PROF KING: Yes. Certainly not two metres.

MR NAPIER: There's an end – that ends at 3.2 metres, at massive great rocks. What I'm saying is that we have all these people that are addicted to this opportunistic power grab with dysfunctional infrastructure. Signs to get into Mindil Beach.

PROF KING: Sorry, yes.

MR NAPIER: It's a bit dark, on the centre right there's a little sign.

PROF KING: Gardens, yes.

MR NAPIER: Yes, that's the one. That was the original sign, ladder and gate 6 centimetres and 6 centimetres, hidden behind a little tree. I nearly come to grief trying to turn around. So the Minister – the Shadow Minister said, "Well, that's a no-brainer", I sent him a photo, and that's what they put, behind a street sign, behind a clearway sign, behind a little tree.

MS ABRAMSON: So your concern is then about public safety and use of infrastructure with those particular examples that you've give us?

MR NAPIER: These people are academically qualified in appointed positions, and they're doing stuff that a 7-year old would do, which is consistent to the traits as listed by Cleckly and Hare under psychopaths.

PROF KING: So the final sheet that you want us to look at is the definition of antisocial personality disorder from the DSM – is it from the DSM-V?

MR NAPIER: Yes. I consider those traits are for a specific – from a professional psychological perspective, for a specific definition. But I feel that for the general public's purpose, that could be polished, so to speak. So there's an Australian-wide definition of being bullied, but in the school classrooms or domestic violence or the workplace.

PROF KING: Yes.

MR NAPIER: And the lack of empathy - - -

PROF KING: Lack of remorse.

MR NAPIER: Yes.

MS ABRAMSON: What would you like us to focus on for our inquiry? If you had to pick a key thing - - -

PROF KING: Just one thing.

MR NAPIER: Identifying what bullying is.

MS ABRAMSON: Yes.

MR NAPIER: Galileo tried to explain to the pope the world went around the sun, not vice versa, and that's how the system is with this bullying thing. They've got it from the wrong perspective.

MS ABRAMSON: So what would be that perspective, Bob?

MR NAPIER: Bullying is an addiction to the dopamine kick in intimidating somebody else for their own self-validation, then there's a second dopamine kick by being able to lie about it. This is all done with FMRI scans, by very clever people in universities. So I was quite - - -

PROF KING: The reference in your submission, and you've got really good referencing things - - -

MR NAPIER: It's quite clear that this is a fact of – the standard – there's a bit on the internet, a gay kid confronts the bully that's been really hammering on Facebook, whatever. Eventually the gay kid loses it, give him a couple of (indistinct). And the gay kid gets suspended for three weeks, the bully gets suspended for two weeks. Now, the currency of bullying is it's not financial, it's not functional purpose, it's about omnipotence, psychological gratification.

By punishing the gay kid three weeks, it's just elevated the bully, he's omnipotent over the victim.

MS ABRAMSON: No, I think we understand the point that you're making to us, Bob. It's a complex area, and with bullying, you know, we tend to look at it through a particular legal prism and we say, well, does that meet the definition, and if it does meet the definition, what are the consequences. But you're encouraging us to look more broadly at it.

PROF KING: Looking through that psychological lens.

MR NAPIER: That APA definition.

PROF KING: Yes.

MR NAPIER: Now, the APA, I can't remember the term for under 15, it makes reference in that to under 15s, they have three different categories, sort of mild, medium and hard core. But in the adult, there's no reference to that effect. But the book, they decide by age 40 they've mellowed off a bit, but commonly are very well known to the police and have spent a fair amount of time in jail.

Now, the people who've done that car park, they don't – never get touched, they're not seen, they're invisible, they're off the glass ceiling and they know how to operate the system. So we have a system that's full of these people. There's plenty of brilliant people out there, we've had a couple of CEOs that are brilliant people in the council where I just come from, and a couple more that - - -

PROF KING: Maybe not quite the same quality.

MR NAPIER: Seriously not very nice people.

PROF KING: Thank you for that, Bob.

MS ABRAMSON: No, I think we understand the point of view that you've brought to us, Bob, and thank you for taking the time to do that, and also for your submission.

PROF KING: Yes, I thought it was a very eye-opening read.

MS ABRAMSON: Yes, no, thank you.

PROF KING: Thank you. And I'll pass you back these.

MR NAPIER: I should say thank you for the opportunity, the opportunity that you might be able to do something where other people might be less impacted.

PROF KING: Yes. No, you want to make a difference. Now, do we contact the next person?

MS ABRAMSON: We do. Thank you, Bob.

PROF KING: Just for your own background, formally we're on transcript there, so we are taking a record of the conversation. Can I ask you to just identify yourself for the transcript initially, and your position, and then any opening comments that you'd like to make.

MS CLANCY: Okay, thank you. I'm Rosemary Clancy, I am a specialist clinical psychologist and a member of both the APS College of Clinical Psychologists and a member of the Australasian Sleep Association. I work at a (indistinct) suite at the Sydney Sleep Centre and also write on evidence-based insomnia treatments at the website www.letsleephappen.com.au and I also work as a clinical psychologist at the Sydney Clinic in Bronte, New South Wales. So have I covered - - -

PROF KING: Yes, that's good. And we've read your submission, post-draft submission, just briefly in a couple of – in a few words, what are the key messages you'd like to get across to us and what would you like us to be recommending to Government?

MS CLANCY: Yes. Okay, so my submission has basically two, prescribe and increase public understanding of the reciprocal relationship between poor sleep and poor mental health, insomnia features, and prescribing culture which accidentally fosters sleep medication dependence long term, and increases overdose risk (indistinct), and I'll be talking about BEACH data for that.

PROF KING: Yes.

MS CLANCY: Then finally, the cost effectiveness and evidence-based for CBT for insomnia, which ameliorates depression through sleep improvement.

PROF KING: Yes.

MS CLANCY: So should I say a little bit about the research behind it?

PROF KING: Yes. On the sleep CBT, that would be fantastic. CBTI, I think, is the way it's designated. But also, very keen – just for you to think of whilst making a comment, medication has come up as a recurring theme in these hearings and in our post-draft submissions, so I'd be very interested also in your views of whether there should be tighter controls on medication, is there over-prescribing. How do we actually deal – if that's an

issue, how we would recommend to Government to deal with it, I'd be very keen to get your opinion on that.

MS CLANCY: Yes, I'd certainly really like to weight into that debate, because the same thing came up at the Sleep Health Federal inquiry last February. So it's an ongoing question and issue, not just for this country but for all developed countries around the world. We see the same issues happening in the US, the UK, Denmark, Norway, France, Germany, Finland. There's a great deal of research into long-term habitual use of these types of medications.

MS ABRAMSON: Rosemary, it's Julie Abramson, I'm just confirming for the transcript, you're talking about the Senate inquiry into sleep health last year?

MS CLANCY: That's right. That's Greg Hunt presided over that. Yes. So I presented something sort of similar to that, but what I'm really focusing on here is the nexus between and the reciprocal relationship between poor sleep and poor mental health. So even if people won't self-disclose in emergency departments with suicidality, they will generally front up for sleep or chronic pain issues, and that's one way to capture them, when they're otherwise quite secretive about suicidality.

PROF KING: Yes.

MS CLANCY: Okay. So I'd like to say poor sleep, and there's just a little bit of the research that exposes an early warning sign of deteriorating mental health and a crisis warning sign of imminent suicide intent. And Shane (indistinct) and he won't disclose this to the emergency department to talk about concerns.

Insomnia is the most common sleep disorder, affecting up to 40 per cent of the population, features of stress and dissatisfaction with the quality or quantity, about initiating and maintaining sleep, frequent waking or problems resuming sleep after waking, or both, early morning waking, inability to resume sleep, and clinically significant distress or impairment in social, occupational, educational and other areas of functioning.

So it occurs at least three nights a week, for probably three months, despite adequate opportunity to sleep. So pre-existing insomnia is a primary factor for depression, 40 to 50 per cent of insomnia sufferers have a comorbid mental disorder, these people are 10 times more likely to have clinical depression and 17 times more likely to have clinical anxiety, and it starts early.

Paediatric research links children's sleep disturbance with anxiety and depression, especially a number of studies done in the UK. So poor sleep affects poor mental and physical health, and poor mental and physical health affects sleep.

The perceived go-to for sleep problems, that is prescription sleep meds, is found by the clinical research to complicate the picture further. According to the Victorian Coroner's Court sleep prescription medications are involved in 55 per cent of 284 overdose deaths in

2014, up from 49 per cent four years earlier. Thereafter the medications Xanax and Valium were moved to the Schedule 8 for restricted prescribed meds.

But what we've seen in the ABS 2016 data on drug-induced fatalities, which showed that benzodiazepines were the most common substance present in drug-induced deaths in 2016, being earlier provided at 653 of the deaths, or 36 per cent. And the most common substance in drug deaths soaring from 22 mid-60s, and the most common substance present in male deaths from (indistinct).

Now, the vast majority of these deaths are accidental. And this means that 440 of those 663 in Australia died accidentally from an overdose that features benzodiazepines. So those medications that they were prescribed for anxiety and insomnia, that they're prone to tolerance and addiction, they're particularly dangerous when taken with other substances, because they cause respiratory depression, and over 96 per cent of those drug deaths where they were present they were mixed with other drugs including alcohol.

So over a 20 year period, (indistinct) found that benzodiazepine dispensing in Australia, using drug utilisation in the Pharmaceutical Benefits Scheme data, shows that 174 million scripts were recorded, with Temazepam, which is prescribed for insomnia, the most dispensed benzodiazepine at 75 per cent.

PROF KING: So to the degree – just on that, Rosemary, to the degree that – I'm not making a judgement here, I'm not a clinician so I'm – what could we recommend to Government to do about that, recognising that GPs and psychiatrists have the training to dispense, have been given, in a sense, the legal mandate to write prescriptions – they don't dispense, sorry, they write the scripts – what should we be doing about this issue?

MS CLANCY: So the GP training it's (indistinct), because Temazepam, the BEACH Study, which I'm sure you know, the Bettering the Evaluation and Care of Health, looked at actual prescribing data of all the GPs and they found 90 per cent of patients presenting to a GP, that GP said, "you've got insomnia" and prescribed a hypnotic medication, and Temazepam is still the most preferred drug of primary care at 50 per cent.

So melatonin, which is – all GPs is less than 10 per cent prescribing. So the prescribing culture fosters easy availability of those medications. So it's an education issue, I think. And this is about – and the difficult years – you know, some insomnia features that cement this, and it's not just a prescriber's underestimation of the harm from this medication in the users, and because of the easy availability, they think it's just the norm or it's – there's not a health risk in popping these, and you don't know about respiratory depression issues. And they certainly don't really think about the way they misconstrue sleep and how the medication keeps maintaining that.

PROF KING: So do you see a part of the education of GPs is making them aware of CBTI as an alternative, a non-medicine-based alternative?

MS CLANCY: Look, that's my primary goal. I think this is really important, because many GPs and patients come to me for the psychological treatment that RACGP is stating that should be first line treatment in (indistinct) prescribing guidelines, and the patients say that they started on the medication as a way of short circuiting the insomnia habit, but the phrase itself is erroneous. You're not short circuiting an insomnia habit, you're just grasping a pill taking habit, which is far more convenient, onto an insomnia habit and maintaining that.

MS ABRAMSON: It's Julie. One thing that we also need to think about though is patient education, because when we speak to GPs about this, they'll say to you that people can be very insistent that that's the drug that they want. So it seems to me there's two parts to this, not just GP education, but community education.

MS CLANCY: Right, yes. Look, I mean, this is – and there should be two prongs to this, it's a gateway really I suppose to why I have a focus on the GP education and training. And also because I'm a member of the Australasian Sleep Association, and it was a prominent issue at the Federal Sleep Health Inquiry.

PROF KING: Just to get your opinion on – I mean, just purely factual. When Better Access came in, and one of the other Commissioners on our inquiry, Harvey Whiteford, was involved in the initial setup for Better Access, and he quite willingly admits that originally they thought there would be a significant drop in the prescription of medications for mental health, and what they found was the introduction of psychological therapy through Better Access, MBS-subsidised psychological therapy to Better Access, had almost no effect on medication rates whatsoever.

So what the GPs started doing was both writing the scripts and recommending that you go and see a psychologist of the person for CBT. So do you see that as being a problem here as well?

MS CLANCY: Yes. Look, there's a couple of parts to this. One is that most psychologists, even though they say they're religious in sleep hygiene interventions, and the problem with insomnia, once it becomes an issue and threatens to be chronic, is that people know very well what the sleep hygiene rules are and in fact they might keep to them too closely and that actually creates performance anxiety about sleep.

So CBTI is about not – well, sorry, it's about valuing sleep but not over-valuing sleep, and most psychologists don't actually have training in CBTI so they don't actually grasp that part. So yes, there is a need for better information to be out there, and this isn't the sort of information that can be encapsulated very quickly and easily on websites, because most people, it actually sounds quite paradoxical to people, that you could be trying so hard to problem solve sleep, but you actually make it worse.

So the difficulty with the medications in particular is because they seem like a go-to because they're cause anterograde amnesia. The hypnotic medications in particular starts with the anterograde amnesia, which is a welcome benefit, by a patient.

MS ABRAMSON: Could I just ask, Rosemary, I don't know what this is. What is that amnesia that you've just spoken about?

MS CLANCY: Yes, so just – so I mentioned that – anterograde amnesia is that while the medication is active you're not laying down your memory, or laying down your memory in bed. It particularly affects dream sleep, or REM sleep, which is important for memory consolidation.

Now, all the major benzodiazepine and BZRA manufacturers warn consumers of confusion and memory loss side effects from the product. Even Mayer the manufacturer of the new sleep medication, (indinext), which was hoped to be an antidote for the dependence – widespread dependence on benzodiazepines, even that warned prospective users of memory loss on the medication. And this matches insomnia sufferers' perceived need, because in insomnia we have biased recall breaking through the night.

We're very poor judges of time, and 11 minutes awake on polysomnography data as a sleep study will routinely feel like over an hour of wakefulness. So the amnesia and sedation feels to users like a solid night's sleep, but it's only cessation and memory loss.

MS ABRAMSON: Yes. No, I understand, thanks.

PROF KING: Can I just – sorry, final one from me is - - -

MS CLANCY: That's people would be clamouring for the medication though because they feared (indinext).

MS ABRAMSON: Yes, understand.

PROF KING: Quick answer. So CBT – to get access to Better Access at the moment you need a mental health treatment plan from your GP, formally it covers CBT, do people access CBTI – well, we know that people access things more than just straight vanilla CBT through Better Access. Do people access CBTI through Better Access at the moment, or is that very unusual? Because I can't - - -

MS CLANCY: Yes. Look, this is – there's a paucity of CBTI trained psychologists in Australia. So that's a (indinext) too. And it's also – because I work here in a psychiatric hospital setting here four days a week, we are not doing sleep interventions, and – we actually do sleep interventions here too. So many of our psychologists and also interns coming through are really focused on therapies like – like CBT and acceptance commitment therapy, and are not necessarily interested in sleep as a specialty. And I suppose it might be an issue too for psychiatry.

So yes, there's – I certainly have numbers but they're – so there are more and more GPs, especially in the Sydney area where I practice, are aware of the evidence base of CBTI and so they're preferentially referring for CBTI.

MS ABRAMSON: It's Julie, thank you very much, Rosemary. We've had a number of presentations and submissions about sleep, so we're certainly thinking about it in the context of our final report. It's not something that we picked up earlier. So your evidence today adds to the weight of a number of very eminent people who've spoken to us.

MS CLANCY: Thank you.

PROF KING: Thanks, Rosemary.

MS ABRAMSON: Thank you very much.

PROF KING: Would you be able to start by stating your name, affiliation just for the transcript and any opening comments that you'd like to make?

MS SPENCER: Sure. I have a piece of paper that I've brought that will be important to me. My name's Linda Spencer, and I became aware of the Productivity Commission through - - -

MS ABRAMSON: You can take a seat.

PROF KING: Please don't stand.

MS SPENCER: You know, standing is nice when you sit all day.

MS ABRAMSON: We're very informal – you're on transcript, but we're quite informal.

MS SPENCER: Great, thanks. So I became aware of the Productivity Commission through the Australian Counselling Association, and I'm a registered counsellor with the Australian Counselling Association.

I feel like there's a lot I want to say, but I brought a little bit of a list that I'll probably like to expand on. So I moved – it's going to be Territory-specific, but I've also lived in Victoria for many years working in the mental health field down there as well, and mental health and drug and alcohol. So my speciality is dual diagnosis.

So one of the things that I've noticed, particularly in the Northern Territory, is community awareness of available services and access to services, particularly in remote communities, is lacking, and I think that would be a really helpful thing to be able to educate communities about how they can access service when there's a crisis, particularly in the more remote communities, but definitely in Darwin as well.

There's a real gap for adults with serious mental health that aren't in crisis. So up here it's called ATAPS and in Victoria it's called VHN. So access to psychological services through ATAPS is – I think it's between six and 10 sessions. I don't have the numbers exactly, but

yes, I believe it's something like that, which is really great for early intervention or a less chronic mental health.

But with the serious mental health issues it really – it's just not enough, and there's nothing in between that and then when you look at the mental health services in Darwin, they're really designed around managing crises, because there's just not enough service to go around, and so there's this whole ream of people that it's having a massive impact on the community and their families and the quality of life, which just is not addressed, I feel.

When I was in Victoria I had a private practice and as a registered level 4 clinical counsellor with the ACA, I could register with one of the cooperatives, if you like, and then be referred clients through the PHN process, up here my understanding is that doesn't happen. So ACA registered counsellors can't be available through the ATAPS process, which seems ironic, given that in Darwin there's even more of a lack of services than there was in rural Victoria.

The other thing that I also wanted to say is that I used to work as a provisional psychologist and was doing that for four and a half years before I transferred over to Australian Counselling Association. And I feel like I've got a lot of respect of psychology, I love the discipline, and social work and also counselling, obviously, and I feel like there needs to be – what I say to my clients is that not every counsellor or every psychologist is right for every client, and that you've got to find one that you really resonate with.

Personally I feel like counselling and psychology is one of the most intimate things you could ever do. You're really becoming quite vulnerable in a session and able to move through your challenges and explore a different way of being. So I think it's really important that there is a myriad of people and disciplines available for the myriad of people that are wanting to access services.

That's not to discredit psychology or social work in any way, shape or form, but it's just to say that even – all disciplines aren't right for every person. So I really feel like it's a big missing to not be able to provide that through the ATAPS process.

I do work for a community health organisation, I'm not representing them today, but I really see that community health organisations are in a really unique position to be able to provide that gap for people with serious mental health illness, so that they're able then to take on the ongoing long-term counselling for the complex mental health that aren't at the pointy end and needing the hospital intervention.

MS ABRAMSON: Can I ask, are any of the clients that you're working with in the NDIS? We know there's a huge cobble of people that aren't, but just kind of interested, because you talked about the severe end, so what sort of percentage of the client base that you work with have got NDIS support?

MS SPENCER: You know what, I couldn't really say off the top of my head, but they're certainly there. Being psychology trained, I love data, and I doubt my own sort of

guesstimates, so I think if I was to have a guess I'd probably say about 15 per cent of the caseload I have now might be NDIS eligible, and I've certainly done treatment summaries to support, successfully, clients accessing the NDIS.

The difficulty with the NDIS as well, particularly for mental health, is that you might be able to get them connected to NDIS and get all the services agreed upon, but then getting the locals who want to work with that person, particularly when you're in a small community, can be challenging.

PROF KING: Can I just follow up on exactly that point? So I think one of the – we've had a number of meetings and hearings and visits to the Northern Territory, and the thing that strikes me is everyone's aware of the need, and some of the submissions put to us, "Look, we just need more funding and things will be right", I think what strikes me though is what we really need is some people. And have you got any suggestions for us, because, you know, and I don't know how this - I don't know what to recommend to government to solve a problem that simply the workforce here, the counsellors, the psychologists, the peer workers, that entire workforce, it's simply far too small to deal with the issues here in the territory. I don't know how we can fix that so if you've got any suggestions?

MS SPENCER: That's a really, really great question and I'm really glad that you're asking it and hopefully you're asking that on a really broad basis, which I'm sure you are.

PROF KING: Yes.

MS SPENCER: I can really only speak personally, so I moved up here with my husband two years ago. He's been wanting to move up here over 20 years and the planets aligned and I said, 'Let's do it'. When we moved it was incredibly financially challenging and also, you know, as you can imagine there's a lot of changes. I'm 50 this year. So there was - even though I'm moving into an area that has great need, there was no financial support for me to do that and the financial support that's available with the government now is along the lines of if you're a sort of family breeding age, if you like, in the hop that they're going to set up family here.

MS ABRAMSON: So that would be territory specific assistance from the Territory Government to encourage migration?

MS SPENCER: Yes, or, I mean, why not ask federal support as well, really.

MS ABRAMSON: We might have a view about that.

MS SPENCER: Yes, but that's true but we're all part of this big country and the territory is a vulnerable citizen, so, you know, one would hope there would be a bit more support in light of that. So the job I had I was working in private practice but I also was employed and I was employed for the same organisation for eight years so you can see that I'm quite stable in my employment history, and I've been with the same organisation since I moved

up here at the start of 2018. So I feel like if that support for people to move up here was extended to the middle aged population and - - -

MS ABRAMSON: You are amongst friends.

MS SPENCER: Even older, you know, like this is potentially a great place to retire. My only concern is the health services and I can see that that would be the only reason we'd move away.

MS ABRAMSON: Can I ask a question about mental health literacy in communities? So as Stephen was saying there's a workforce shortage which doesn't have easy answers to it, but what about mental health literacy amongst communities, especially given where you are? I'm looking at Matt whose question it was, so hopefully I've got it right.

MS SPENCER: Yes. What was that question that - - -

MS ABRAMSON: It was about mental health literacy in communities?

MS SPENCER: Okay so I will just be really transparent here, I'm based in Palmerston.

MS ABRAMSON: Yes.

MS SPENCER: I do sometimes provide supervision and support for Tennant Creek. Personally I think we really need to work with who we've got in the communities, and the way that you'd work with a community wouldn't be the way you'd work with one in a city, if that makes sense?

PROF KING: Yes.

MS ABRAMSON: Yes, absolutely.

MS SPENCER: You have to make allowances. So in terms of the health literacy I think I can only speak from the staff's perspective, and that can vary. That can vary. So that what I've noticed too is that in communities the demand on the services is enormous which creates its own issues around recording and meeting requirements for funding bodies, and things like that.

MS ABRAMSON: Do you think are there any particular gaps in the provision of youth services here or is it just general gaps through the whole cohort of people who need mental health support?

MS SPENCER: In our office there's a real gap for the adults. We have just had a youth mental health service team start, which is two, a case manager and a case manager/counsellor, if you like, for the serious mental illness that's not at the pointy end and needing crisis intervention. We don't have that for adults. And we've also got a drug and alcohol team specific for youth as well, yes.

PROF KING: Thank you, for coming in today.

MS SPENCER: No worries.

MS ABRAMSON: Thank you for making the effort to be here today.

PROF KING: Yes, thank you. The next one we're doing is by phone.

MS ABRAMSON: By phone.

MR VAN DER SMAN: My name is Jos Van Der Sman and I live at Lilydale in Melbourne and I've been a bipolar sufferer for about 40 years and my story is how well I've coped without medication, which I'm doing currently.

PROF KING: So do you mind just very quickly summarising, you were placed on medication as I understand when you were quite young, at 21?

MR VAN DER SMAN: That's right.

PROF KING: And then you found that even though you felt that you could function better without the medication you had issues with the doctors, can you just briefly run through those?

MR VAN DER SMAN: Yes, basically when I brought up the subject of reducing my medication because I no longer required a full dosage there was no discussion about that, they just said, 'You have to take it for the rest of your life and we can't talk about it because it probably won't work if you are taken off the medication'.

PROF KING: And was that just one psychiatrist or one GP, or was it a range of - - -

MR VAN DER SMAN: Yes, it was several, two or three psychiatrists.

PROF KING: Okay so as I understand it you've now gone off the Lithium?

MR VAN DER SMAN: That's right.

PROF KING: How did you do that as I understand there can be medical consequences - I'm not a doctor, by the way, so it's very much second or third hand, as I understand there are potential risks of going off medication, so how did you manage that process, was there any support for you?

MR VAN DER SMAN: There was no support for me so I had to make it up as I went along and I just gradually withdrew the dosage.

PROF KING: What feedback did you get from your GP, your psychiatrist, whilst you were doing that?

MR VAN DER SMAN: They were not aware that I was doing it.

PROF KING: Were you seeing the GP or psychiatrist whilst you were withdrawing from the medication, you said they weren't aware, does that mean they didn't notice any change in your clinical symptoms?

MR VAN DER SMAN: I think I'd stopped seeing them about the same time taking myself off medication.

PROF KING: So this is a number of years ago, I understand, so around 1983?

MR VAN DER SMAN: That's right.

PROF KING: That you downsized, and are you completely off the medication now?

MR VAN DER SMAN: Yes, I have been since 1983.

PROF KING: How, well, first, are you a - do you continue to have symptoms, if so, how do you manage them, or are you - I'm trying to remember - do you have no symptoms, asymptomatic, I think is the word, but how is that going?

MR VAN DER SMAN: Yes, I have occasional symptoms but with bipolar you can get highs or lows, I was mainly getting highs, and I was managing them by a change in lifestyle and making sure I'm physically tired and making sure I have enough sleep.

PROF KING: So is sleep a key part of just maintaining your health?

MR VAN DER SMAN: Yes, it is.

MS ABRAMSON: Jos, it's Julie Abramson, there are a number of support groups now available for people with particular disorders, so you made the decision personally to come off the medication, is there a way that people could be provided with support through, you know, some of the sort of consumer led organisations?

MR VAN DER SMAN: I was in a support group called Grow and that met about once a month but no one else in that group was doing the same thing as me so I felt quite isolated from them.

PROF KING: Sorry, when you say doing the same thing as you, you mean - - -

MR VAN DER SMAN: Reducing my medication.

PROF KING: Okay, but it was the other people in the group were also had bipolar or it was a - - -

MR VAN DER SMAN: Yes, some of them did, yes. Yes.

MS ABRAMSON: And one of the reasons I was asking is we're very aware of the importance of the consumers being at the centre of mental health services so we're quite interested in how we could provide support for people in that consumer set. So it's not a medical intervention it's really about giving people support in the community, which is why I was asking about support groups.

MR VAN DER SMAN: Yes, that's right. And I think that my case shows that it is possible to do what I did.

MS ABRAMSON: Yes.

MR VAN DER SMAN: But with support I would have been a lot better off (indistinct) of saying that.

MS ABRAMSON: And Jos, what would that support have looked like?

MR VAN DER SMAN: Basically an agreement that I'd have my dosage reassessed and then depending on that assessment whether it would be suitable for me to reduce my dosage or not.

MS ABRAMSON: Do you feel in the intervening years that things may have changed, that as I think Stephen said, it was 1983 when you began that journey, do you think that there is a more openness amongst clinicians now?

MR VAN DER SMAN: I'm not sure because I haven't seen a psychiatrist since then.

MS ABRAMSON: Yes.

MR VAN DER SMAN: So I'm unaware of current treatments.

PROF KING: Now we're obviously making recommendations to government and I notice that one of your points relates to psychiatrists and their procedures with medication, medication has come up as an important issue in a whole range of areas; the issues of over medication; the difficulty of getting advice to try and lower doses of medication; you suggested as I understand psychiatrists have procedures, do you think that would be enough or what more do we need to think about other than advising the psychiatrists?

MR VAN DER SMAN: Yes, I think the protocols need to be changed. Where at the moment psychiatrists may think, right, I've got this patient on the right dose, I'm going to stay him sticking there and leave him there because I know that works for him. And they

need to re-evaluate their procedures to the extent that by putting the patient first they will be happy to reassess the patient even though the patient is unhappy where he is.

PROF KING: All right. Julie, anything else?

MS ABRAMSON: Just thank you for sharing your story with us. As I said, one of the most important things in this inquiry is that people with lived experience have the opportunity to contribute and we know it's not easy to do that so thank you for taking the time to talk with us?

MR VAN DER SMAN: Thank you, and if there is an ongoing inquiry or a follow up for the medical profession I'm happy to participate in a meaningful way.

PROF KING: That would be fantastic, Jos, so thank you, very much.

MR VAN DER SMAN: Thank you, very much. Goodbye.

PROF KING: Hi, is that Philip?

MR BENJAMIN: It is.

PROF KING: Hi Philip. Stephen King and Julie Abramson from the Productivity Commission. Thanks for joining us. We are on transcript because it is a public hearing. So if we can start off, if you could just state your name and any affiliation for the transcript, and then any opening comments you'd like to make.

MR BENJAMIN: Thank you, yes. I am Philip Benjamin. I'm not appearing on anyone's behalf except my own. I have mental health experience and I have been working in mental health for 45 years. I am employed in Queensland, but I'm not representing Queensland Health support.

PROF KING: No, understand, yes.

MR BENJAMIN: Yes. So I've been in Melbourne since the 70s at Larundel Hospital, and was lucky enough to get some training in psychotherapy during that period, which has kept me in very good stead. I've been working in what is now called community care centre; at that time it was called productive teams since 1996, for a brief period when I worked at the education unit.

I actually sat on the Board of Trustees for Inwood, which is an international organisation supporting the hearing voices mental health, the hearing voices approach. I'm not sure if you're familiar with that, but very interesting approach to experiences people have when they hear other voices.

PROF KING: Yes. Early on in the inquiry, we had some evidence presented on hearing voices, or the hearing voices approach, yes.

MR BENJAMIN: Excellent. So the reason I'm interested in contributing to the Commission is - I had a scan through the report; I'm sorry I haven't been able to read it all.

PROF KING: It's very long.

MR BENJAMIN: It is, yes. I just searched for the word "trauma" and noted that really the only references to trauma in a systematic way were the ones who had experienced it. But I soon realised, after I began working, the emergency department back in Melbourne, a lot of people who didn't make it through to the mental healthcare system because they weren't deemed seriously sick enough. They'd experienced a lot of trauma in their lives.

PROF KING: Yes.

MR BENJAMIN: Which when you start looking at it, it soon became obvious when you look at the data particularly Defence people with serious mental illness, that they've experienced trauma.

PROF KING: Yes.

MR BENJAMIN: So I expect there is a protect when I was studying for a masters at Monash in the mid to late-90s. Just that the clinician is helpless when discussing past sexual abuse particularly, and with the result, and not surprisingly, assistance of clinicians, they're not able to respond or even enquire about past trauma. So it's become a hobbyhorse of mine in a way.

PROF KING: Sorry, can you just back-up there, just one second. So with regards to clinicians enquiring into past trauma, can you - - -

MR BENJAMIN: You want some more detail on that?

PROF KING: Yes, please.

MR BENJAMIN: Okay. Well, at the time I was working at Northwestern Health in Melbourne. And I accidentally came across a policy which was called – a policy about past sexual abuse. In fact a policy about the enquiry about past sexual abuse. And as I was studying for the master's at the time and looking for a research project, I found a tool that was developed by some mental health nurses in Montreal, and had been known as the sexual abuse compass scope.

And I managed to get consent from the organisation, actually it was fortuitous because I'd applied to the Director of Mental Health at the time. I could see him baulk at the idea of inquiring about past sexual abuse, and it occurred to me that this man had probably had some experience himself previously. I knew the authority quite well and he was in the room at the time, and I was able to adduce support to produce a – to go into that research.

PROF KING: Yes.

MR BENJAMIN: So I emailed out a digital copy of the film, which was really asking about how comfortable people are. What was interesting, the results went up statistically significant, and what was apparent was that the longer that a clinician had been working - and that didn't depend on their age, but their duration of service - the more comfortable they were. But the nurses and doctors were much more comfortable, ironically, than psychologists and social workers.

But still, the levels of comfort were very low.

PROF KING: Okay. I mean, it's an important point because we've heard a lot during this inquiry about the importance of trauma-informed care. I recognise I'm not a clinician but there appears to be different views in the literature about the degree to which mental health issues (inaudible) or issues are currently occurring.

MR BENJAMIN: My reading of the literature is that people who are exposed to trauma as adults are much more vulnerable to those experiences, if they have had trauma or neglect in their childhood. I mean, in fact, I'm sure you're familiar with the age of the study, which was done by a (indistinct) in the 1990s in the United States, and there's somewhere like 60,000 enrollees in their issue.

And what they determined was that there was a balance who did they affect, which is in a sense common sense and so when you try and identify the effects, they'd be very personal; you know, some people obviously take trauma in their stride and others are devastated but it. Some people are able to use it as a leverage point to improve their health and make a significant contribution, like people like Cathy (indistinct) but with others, they're devastated and clearly, never recover.

What I do clinically - and I still work in emergency departments in Brisbane - a lot of people who are having problems to deal with, starting with me, have had some really terrible experiences in their lives, and I'm wondering what might've happened to you. And that's not a direct question, but it's an assertion of my view and I just miss the point but really often, because - and when you look at the literature, the evidence is that people are more traumatised when they go through these experiences.

I had a woman in the emergency department in Brisbane just a few days ago who told me that she had been sexually abused by a cousin, from the ages of five to seven. And when she told her mother, the mother had continued to allow this child, this cousin of hers, to visit the house. And so there's betrayal in a sense. And the mother had her own mental health issues. The father in this situation was a very violent alcoholic and the mother was suffering from her own mental health problems.

But I think the reality is that the situation, because it provides no opportunity for people to recover. And so one of the points I wanted to make to you was in my view, the diagnostic criteria only tends to be relevant to various people. My own view is that the most important

measure is complexity. If we have someone who presents with some stress that's caused by an incident and they don't have a complete social situation or background, there's nothing you could do with them, and these are the people who are probably still in the mental healthcare plan approach, where you get, you know, ten seconds, whatever it is.

PROF KING: Yes.

MR BENJAMIN: Sit down with a counsellor who has appropriate training but if you've got a complex background, that's a completely worthless exercise because the standard CBT model (indistinct) put up with, only those who've experienced it. Like, it doesn't help them at all, these are some bigger issues.

PROF KING: Yes. I'm married to a psychologist, so as well as the information from here, I've been informed CBT is useless for trauma.

MR BENJAMIN: Yes. And it (indistinct) but if you're saying to someone, "Just change the way you think about a situation," they're (indistinct) I mean, I think in a sense - my background is from a Jewish family, and my brother-in-law's mother is an Auschwitz survivor; she's now 99. And so I've grown up with people who have survived clear trauma, and to me, it's the reality that they don't forget.

The experiences are embedded in their daily experiences. People are triggered by the most minor things, you know? I mean, pressures of someone walking past can be a significant trigger. And I wanted to think that – interestingly I was going to bring up – I belong to an email discussion and recently - not in the context of the murder/suicide in Brisbane this last week, but in terms of – in general terms of people's human rights.

There was a couple of clinicians from Australia who described their clients' experiences – particularly two women who were described with horrific experiences of abuse from neglect in childhood, and some trivial incident were tackled to the ground by a group of usually big tough men who proceeded to manhandle her into an isolation cell, which is really what the treatment was about.

Different (indistinct) subjected her - and left her naked in this room for a period of hours. And they used a really really traumatising experience.

PROF KING: Can I ask you then, just we're obviously making recommendations to government.

MR BENJAMIN: Yes.

PROF KING: And obviously a key issue on the clinical side is trauma, re-traumatisation, making sure that the appropriate care for people who have trauma-based mental health issues is available. In a sense, we're sort of covering-off on those, so we're recommending that the access to psychological therapy be expanded, initially on a trial basis, and cover things like EMDR and other appropriate approaches to deal with trauma.

MR BENJAMIN: Yes.

PROF KING: What else would you like us to recommend to government? If you had one thing you want us to say, "Government, you should be doing this," what is it?

MR BENJAMIN: It is a national (indistinct) of two things; one is - I should've mentioned it a minute ago - one is that I was lucky enough to be in (indistinct) for the last year in September at a conference, and I'm not (indistinct)

PROF KING: Yes. No, no.

MR BENJAMIN: Okay. So they have an annual conference, and last year's conference was focused on human rights. And there were some presentations by people running pilot projects in Europe, where the emphasis is on the idea that people's illnesses are derived from an abuse of their human rights and therefore, the only rational response is to act in a way that reinstates their human rights.

But a number of presentations where the services had opened their doors and were imposing on people to be - and in fact (indistinct) for hospitalisation (indistinct) they had, in fact, closed all their mental health services, all their in-patient services (indistinct) but what I was going to say was that there was more than (indistinct) the World Health Organisation, exactly (indistinct) from Sydney and (indistinct) and the chair and her team have developed an online training program called Quality Rights, and they've rolled it out in some jurisdictions in Africa and noticed a significant improvement in the application of human rights.

MS ABRAMSON: Phillip, it's Julie Adamson. What was that lady's surname? It was Michelle?

MR BENJAMIN: S-u-n-k

MS ABRAMSON: Thank you.

MR BENJAMIN: So she's a very sophisticated thinker and this – I've had a look at it myself, and I was very impressed with what she does for the World Health Organisation website or I can send a link, if you like.

PROF KING: No, we'll follow-up on that. But you did say there were two things that you wanted.

MR BENJAMIN: Yes.

PROF KING: What's the second?

MR BENJAMIN: When I was (indistinct) not fair. When I worked on the Sunshine Coast, I did some (indistinct) in community mental health, so I worked on a ward in Nambour. And (indistinct) was in there, because so many of these wards are staffed by people who use - completely contrary to mine in the way the people can be cared for (indistinct) use that approach.

And I was very impressed. There were two English trained mental health nurses; one was CMC, one was the educator. And they had taken nothing but (indistinct) to them for (indistinct) reduction programs, which was in 2014 I think, or 13. And they had taken all the staff on their ward offline and given them some real (indistinct) there. And he had (indistinct) there, there was one (indistinct) and then after three years, most of the staff had moved on, there was a new unit manager and I wasn't working there at the time, but she was quoted to me as having said, "The problem we have in this ward is, we don't use our (indistinct) which is a long-term highly-sedating anti-psychotic, if I can use that term.

I mean, none of them are really anti-psychotics. Until you become aware of that, they're all just tranquilisers. And we don't (indistinct) enough inclusion. So (indistinct) said all staff, because one of the (indistinct) trends about to increase it (indistinct) everyone has quality rights across the nation. I think they'd be huge (indistinct) understanding it.

PROF KING: Aware of the time. Can I please thank you very much for your testimony here today? I found it very useful, so thank you.

MR BENJAMIN: Yes. I think the other thing that I might mention is that - I'm not sure (indistinct) public policy (indistinct) communication I think, at ANU. But he was the senator, public health in South Australia in the 80s, and in 2008 he presented (indistinct) and he - it was public policy for South Aussies. I remember being a fan of the - even South Aussies (indistinct) according to (indistinct)

And that is that the benefits that accrue from some policy decisions accrue in a different jurisdiction or a different department in public health, so you get this approach that people don't - you know, through all the - - -

PROF KING: Yes, they don't co-ordinate across jurisdictions, because, "I'm not going to spend money in my jurisdiction when you get the benefits."

MR BENJAMIN: Exactly.

PROF KING: Yes, we're well and truly aware of that, and particularly - well, in a federation like Australia.

MR BENJAMIN: Exactly. I mean, the other thing that I wanted to raise with you is there was a research project in Sydney in the early-80s (indistinct) and Allen Rosen was involved in that at the time, where they randomised people (indistinct) was the Director of Macquarie Hospital at the start. They recognised people for home treatment and in-patient care, on

the basis that people (indistinct) important predictors for people being admitted to hospital wasn't going to (indistinct)

And they did a randomised control (indistinct) and the results were outstanding. And that was the beginning of the model that we now (indistinct) to care. However, the facility that involved has been completely off. That's actually a home-treatment service, and I'm sure you (indistinct) as well, which is also a home-based treatment service.

The evidence (indistinct) is that home-based care is much more cost-effective and much more clinically effective than pulling people out. There is a society in Sydney called (indistinct) professional men, I think mostly who are (indistinct) developing open-dialogue in Australia, and we (indistinct) some open cases which actually demonstrated that in a family system, often people in home-based care, even though it's much more intensive (indistinct) in a way, but if you offer intense intervention early on - and this (indistinct) the model (indistinct)

Where you get much (indistinct) down the track. And so I think the first thing I would say to government is that what's really necessary is implementing home-treatment teams, not (indistinct) so the people are able to engage with their families. I mean, I really like to forward this full paper to you, because I think it's very important; so perhaps I can do it to one of the people who have emailed me?

PROF KING: Yes, please do, to any of the team members that you've been in contact with.

MR BENJAMIN: I've got Matt and Erin's emails, so I'll forward that to them.

PROF KING: Yes, that would be fantastic. And again, we have seen quite a bit of evidence on the benefits of keeping people out of institutionalised care.

MR BENJAMIN: Yes. I mean, one view is that in many cases, schizophrenia is probably a genetic disorder.

MS ABRAMSON: I should say - it's Julie Abramson.

MR BENJAMIN: Yes.

MS ABRAMSON: We've also got a recommendation: we'd like private health insurers to be able to do more in the community; so that is about providing home-treatment. So certainly, very (indistinct) of that.

MR BENJAMIN: Yes.

MS ABRAMSON: But thank you for taking the time. It's really been incredibly valuable, because you've been at the coalface of mental health service delivery. So thank you so much.

MR BENJAMIN: It's been my pleasure. And if there's anything I could do to help in the future, please let me know.

MS ABRAMSON: Thank you.

PROF KING: Thank you.

MS ABRAMSON: Thanks very much.

MR BENJAMIN: Yes, thank you. Bye.

PROF KING: If you could please state your names, the organisation that you're representing, and any other comments you would like to make for the transcript?

MS LETHLEAN: Hi, Vanessa Lethlean, Managing Solicitor at the Top End Women's Legal Service.

MS WEATHERBY-FELL: And Caitlin Weatherby-Fell, the Senior Solicitor at the Top End Women's Legal Service.

MS LETHLEAN: We've just got a really brief opening.

MS ABRAMSON: If you'd be kind enough to speak up a little bit? The microphones are not for amplification; they're just for the transcript.

MS LETHLEAN: Okay.

MS ABRAMSON: Thank you.

MS LETHLEAN: Okay, so the Northern Territory has the highest incarceration rates in Australia, for both women and men. And in the Northern Territory, almost half are convicted of a violent act, which is the connector with DV.

Our service, the Top End Women's Legal Service, has been providing services to women in the greater Darwin region for over 20 years; for the last 10 years, we are the only family and civil law provider of legal advice to incarcerated women in Darwin. We currently attend Darwin Correctional Centre every third week, and we have over a hundred open legal matters. In the last five years, service demand has increased by 500 per cent, and so have our KPIs, but funding remains as it was; so there's an increasing service gap.

We welcome and endorse the draft report, the focus, the findings, and the proposed draft recommendations in relation to the mental health needs of women who are incarcerated. Unfortunately, the number of women incarcerated in the Northern Territory has, in fact, increased by 440 per cent between 2004 to 2014; and a large part of that is for four reasons:

Women have multiple, unaddressed, pre-existing vulnerabilities which are compounded by the incarceration. And women present with really high-level complex trauma, and they do require therapeutic service provision, to both address recidivism, but also the foundational issues, but there is none available.

There is assistance focus on criminal acts and criminalisation, and there's very little consideration given to holistic responses, and very little consideration given to some of those foundational issues, which of course are family and similar matters.

And also, the women who are incarcerated really are devalued and invisible to the policy systems on the structural level. So a really clear example of that is when they built the prison in Darwin. The women's sector is completely surrounded by men who are incarcerated, and immediately next to high-risk serious male offenders. And that's a failure, and it's got really substantive implications.

So from our perspective, and the research shows, domestic family violence is a foundational issue for a broad range of women's offending, and it's very significant in relation to the increasing incarceration rates.

In 2019, the number one non-legal ask for women who are incarcerated in Darwin is access to specialist domestic family violence, trauma-informed, culturally appropriate counsellor, and unfortunately that's not available at all, and our service has worked for years to try and bring that to be.

So it's very clear for women who are incarcerated in Darwin that access to such counselling is pivotal, and it's a really crucial step to breaking both the cycle of incarceration and for domestic family violence, which are really foundational to their health and wellbeing in therapeutic hands. The ongoing service gap really is a lost opportunity to reduce both the contact and the costs associated with the criminal justice system, and the impacts for community, for family, and the individuals.

And just by way of summary, the Northern Territory Coroner has described domestic violence as a contagion, and the Ombudsman, a decade ago, indicated that women constitute a small but growing part of the NT prisoner population. And it really presents an opportunity here to get things right, and from our perspective, a positive way forward on both fronts, really, is to make provision for a specialist domestic family violence. And I really don't want to be here for another decade, with this issue unaddressed.

So that's our opening comments and of course we've made two submissions.

MS ABRAMSON: Look, thank you very much for that. I've got some questions I did want to ask you, but I suppose on the domestic violence issue, it's not that the Commission didn't understand that it was an issue; we're certainly looking through the mental health lens. So perhaps some commentary on sort of social determinants of health, but because we're a mental health inquiry, we didn't go for that, and we've had other things, especially with the Victorian Royal Commission into domestic violence who've said well, you haven't

really dealt with it. And that was just because he - it was such a broad inquiry. But we understood the issue and I understand your submission.

So I wanted to ask you, we've got a number of recommendations about diversion and I'm really interested because it all operates differently depending on the jurisdiction that you're in, so what's the experience in the (indistinct) of diversion programs? Are none of your - your clients actually have the ability to refer to a diversion program?

MS LETHLEAN: I guess the comment I would make is that the Northern Territory has an Aboriginal Justice Agreement.

MS ABRAMSON: Yes.

MS WEATHERBY-FELL: And a draft Aboriginal Justice Agreement.

MS LETHLEAN: Yes. And underneath that lies a pilot project that's currently operating in Alice Springs that includes diversion, so housing and some additional service provision. That's great because we don't have a criminal legal practice; we wouldn't be the right people to comment on the availability of diversion.

So our point of contact for women who are incarcerated is at that point. We run quite a large practice and we can see them on other occasions in an unrelated way. But can I just comment on this issue to do with domestic violence.

In our experience a large number of our clients (indistinct) focus on the prison, have mental health issues, whether it's post-traumatic stress disorder, whether it's depression, whether it's drug and alcohol which is (indistinct) because they're not coping with (indistinct) that day to day reality because of a whole range of trauma that's occurred. And so whilst the presenter statistically might be an indicia of domestic family violence if you explore it, it's in fact a really high level complex psychological issue that does warrant and should receive an appropriate response.

These are women who are predominantly mothers, so we're talking about children where there would have been exposure. There are also quite often significant within the cultural context which means that they're holders of a whole range of responsibility and knowledge. The impact of the removal is quite severe. And it's part of that vortex and part of that critical mass and it's a fantastic opportunity while the numbers are still low, comparatively, to go in and do what you're talking about. Some really early work prior to incarceration and also to offer it in incarceration. Absolutely there. And absolutely possible.

MS ABRAMSON: Yes, I think, one of the other things that we've observed, our (indistinct words) I suppose is because we're looking right across Australia and they're a different system but we also observed that there weren't standards for the type of support that you should have for mental health in the prison system or we couldn't find one. And yet in the community, I'm not saying we (indistinct) them, but at least there was a bench bar. These

were the things but we couldn't find them in the prison system and I'm assuming that would be the case in the territory as well.

MS WEATHERBY-FELL: Very much so.

MS LETHLEAN: That's absolutely the case and the territory doesn't fair as well as some other jurisdictions in terms of what is actually available. But from our perspective, we would say there was a standard. And the standard across all of Australia is that access for people who are incarcerated needs to be the same as access for people who are incarcerated needs to be the same as access for people who can't and that's a stumbling block. We've definitely done third party representative complaints where we're quite proactive on this issue because of the impact and the potential benefits that can be achieved and so that standard which is universal across Australia is not being afforded from our point of view to women and clearly the men, but that's not (indistinct words) who are in the Northern Territory.

There's a range of ways to address it, we appreciate that Corrections doesn't have a budget for that but the Commonwealth can certainly look at the regulations for Medicare rebates because those services are not available on a Medicare rebate. So in the Northern Territory, we could have, as we are aware of, a culturally appropriate trauma informed indigenous specialist who would go in on a Medicare rebate basis but can't and the reality is that the services that exist in Darwin for domestic family violence don't have the capacity to attend.

MS ABRAMSON: On the capacity point, I think it was before you joined us, but there were very different workforce issues, so even in the ideal world if the funding were available presumably we would still have workforce issues. So I'm interested in your views on that.

MS LETHLEAN: My backdrop comment would be if you want to get bang for your buck, you go to the specialist and you locate them appropriately, so this mainstreaming approach which is occurring is not the best outcome for clients because funding that's dropped its services who don't have that history, who have to recruit, who have to make support, there are appropriate NGO's in Darwin where if the money was made available, they hold that expertise, they hold the support and the ability to network, to facilitate, appear in a discussion. And that's where we would say the money is best spent or best located.

MS ABRAMSON: So you're - in your model, even (indistinct words) relevant to those organisations, (indistinct) for Medicare to (indistinct words) the money. That would mean that they could see the support workers and peer workers into the prison system for work (indistinct words) incarcerated people.

PROF KING: Sorry. Just how much though - I wonder how much also needs to be - from the indigenous population needs to be in community. So I guess from two perspectives, one is that since (indistinct words) individuals have got on the justice system radar, since (indistinct words) the interventions really should have been from the technical perspective before (indistinct). And secondly, that you can have the best possible treatment in a prison

system but if the woman is going back to a dysfunctional relationship which involves domestic violence, she's simply going to be traumatised. You know, we try to put a band aid on the wrong part of the cycle in metaphors, but views on that. I mean, you're seeing a particular half of what I see as being a much longer spectrum (indistinct words).

MS WEATHERBY-FELL: Well, that's (indistinct words) building intervention with people much younger so they can make healthier decisions and they have a healthier path forward, is absolutely in that foundation of - but the reality is that these issues are underlying incarceration and there is nothing available at that point. (Indistinct) contact points represent an opportunity and it may not be the best, but it would be - or the earliest point, but it may well have been really important for that person to address what's part of their day to day reality. And I understand your question in terms of indigenous women, as also wanting to choose (indistinct words).

PROF KING: Of course (indistinct words). Yes.

MS WEATHERBY-FELL: I think the issue on community is extremely complex in terms of again, critical mass on community. My - I guess my initial comment (indistinct words) you don't have connectivity, you aren't structured appropriately with the appropriate workforce, again, you just don't (indistinct) the outcomes that you (indistinct words) money. And it means you need specialists, you need culturally safe, competent services that go in - and not generalist services that don't hold that.

Services really that are able to develop those key relationships that are necessary to facilitate that ongoing kind of learning and support system that, you're right, is needed across the whole spectrum of that cycle, not just at this point where we're talking about now where someone has already entered into the justice system, has been incarcerated for X period of time. But as the report noted, this is a great opportunity, it's the gateway for these women to receive that support and for our service we'll often see clients who were able to assist with a number of matters which have contributed to her incarceration so that when she is released, she's in a much better position than she was prior to hopefully addressing that issue of (indistinct words).

PROF KING: Can I pause there now to ask - and apologies because I put two questions together and so (indistinct words) making a (indistinct words) Aboriginal and (indistinct words) so my apologies. I was actually referring to the (indistinct words) survey (indistinct words) domestic violence and trauma counselling. And my understanding, and I'm not (indistinct words) but my understanding is that women who for example are suffering from domestic violence, even if they still receive good trauma therapeutic service in, say, prison situation, if they then go back to the situation of domestic violence, it's simply going to be traumatised with not actually solving the issue and is that your understanding? And understand that you know with some of these at least we get a contact point, at least we get something better than nothing, but it's a bit like, you know, if I can do a workplace analogy, someone slips over on an oil slick or breaks their leg, we send them to hospital, fix the leg up, we send them back to the factory with the oil slick floor there again, we shouldn't be surprised when they come back to the hospital with a broken leg again. In some ways, do

we risk that happening to women subject to domestic violence where because we're not actually addressing the underlying problem of domestic violence in the community – in the broader community, to make it clear, we're not solving the problem. We're just simply setting up the cycle again.

MS WEATHERBY-FELL: It's a really important part of the picture, though. I accept what you're saying, that within the broader community, gendered violence starts somewhere and that needs to be addressed, both with young people, older people (indistinct) in the community. But part of our response about a need for a counsellor, a specialist and a family violence counsellor at the prison is that that counsellor needs to be external, okay, for therapeutic reasons, but also as a potential point of contact post-release, and if that connect is solid – and we certainly see clients who have said, 'I've seen this counsellor, that connector was good to me', and they'll return. So there's a period of time where if there's a good connector made, that can continue post-release, and no, it won't perfect if people are returning to a remote community and I think that's an issue that we don't claim expertise on other than to say fly in, fly out.

MS ABRAMSON: Can I ask you, it may not be in your area, so that's – I'll ask you some other things, but mental health tribunals, we have – we were quite surprised – well, not surprised. We knew that legal funding was constrained – legal aid funding – but it seemed to us that the most vulnerable of people were not necessarily getting supported by the legal or other support services in appearing before mental health tribunals, and the evidence was quite stark that when people did have representation of either form, that actually, compulsory treatment orders were much less likely to be issued. So do you have some experience in that area?

MS WEATHERBY-FELL: It's not a practice area that we hold strength in, so I'd prefer not to comment on that. I think you need to talk with someone who's consistently there, who has a high, you know, percentage of their workload. So the funding in Darwin for those services is shared by the Legal Aid Commission as well as NAJA, the Aboriginal Justice Agency. That's in Darwin, at the very least.

MS ABRAMSON: Could I ask you about the legal aid funding, because you made the point that the national legal aid funding is only available for criminal matters. But there is some funding, isn't there, made available in Family and Civil where it's so tiny it's not noticeable?

MS WEATHERBY-FELL: The comment there really is about – the Commonwealth has a formula which is relevant for the assessment and that weighting only goes for criminal law matters, and you'd have to talk with the Commonwealth about how significant that is. But from our service's perspective, it's again one of those four factors where the priority is given to the criminal charges, the criminal process, and I'm unclear why there is no weighting within civil and family law matters for women who are incarcerated.

MS ABRAMSON: Have you got any?

PROF KING: No, I'm good. Thank you very much.

MS ABRAMSON: Thank you.

PROF KING: That's been really – and thank you for this.

MS WEATHERBY-FELL: Have a good day. Enjoy Darwin.

MS ABRAMSON: Yes.

ADJOURNED

[10.34 am]

RESUMED

[10.37 am]

PROF KING: Now, just for your information, we are on transcript because it is a public hearing so if I could just ask if you could state your name, any affiliation that you have for the purposes of the hearing and the transcript, and any opening comments that you would like to make.

MS PILTZ: Good morning to you, both. I'm Hristina Piltz and I'm appearing today in a personal capacity, I'm not representing or speaking on behalf of any organisation, however in the interests of transparency and disclosure I should note that I have spent several years working for a large global pharmaceutical company and that professional experience very much is gone to aiding my submissions and the remarks I'm going to be making today.

I've also been a carer for a family member who was preventatively medicated for a mental illness at a very young age. I'm really grateful for this opportunity. I've contributed to some other Productivity Commission reviews and Senate inquiries and in that time I don't think I was in such a large community response driven submission process so it's pretty clear you've taken on something that's of great significance to the Australian community. In terms of - sorry, are you there?

PROF KING: Yes.

MS ABRAMSON: Yes.

PROF KING: We're listening, yes.

MS ABRAMSON: We're listening.

MS PILTZ: Okay, so I will just I guess read through my opening statement. As I've outlined in my submission, my key concerns are around the early childhood recommendations in a later report. I'm in complete agreement with the conclusions that

early intervention is absolutely essential when it comes to mental health and it is registered as being our resources. But intervention has to be evidence based and in my professional opinion it would be ignorant and dangerous to enact the early childhood recommendations prior to some much needed legislative changes to ensure that children are kept safe.

And what I'm particularly speaking about is demonstrated practice of off label prescribing. I may just explain what I mean by off label prescribing with a non-mental health example. So off label prescribing is when a doctor prescribes you a medicine for a condition that the Australian regulator, the TGA, hasn't deemed it to be safe or effective before. So let's say, for instance, you're pregnant, which is an example I recently went through with my friend because it was what had happened to her, and you feel nauseous and you go to see your obstetrician and he prescribes you Zofran.

Now Zofran is registered on the ARTG, that is the drug company has provided the TGA with safety and efficacy data but the safety and efficacy data demonstrated that it was safe and effective for use in cancer patients that were experiencing nausea from chemotherapy. So if your doctor prescribed, you were pregnant when you took Zofran, for your nausea, we would say that it's an off label prescription.

PROF KING: Yes.

MS PILTZ: So, yes. Now why would a doctor prescribe such a product to a pregnant woman, you may ask, there's not a lot that make sense and is somewhat reckless, I certainly don't think it's because the doctor wished the mum or the baby any harm, my industry experience would suggest that it may have something to do with a lack of disclosure around how industry engages with the academic community and the professional prescribing bodies that often write the clinical guidelines that guide clinical prescribing practices.

Now interestingly for that example that company was sued for \$3b and they paid that fine but based on my friend's experience she was prescribed that product three weeks ago in her first trimester when TGA guidelines actually state very clearly that it causes birth defects and should not be prescribed in a woman's first trimester. So you could kind of go, well, hang on, the company is fined how could doctors still be prescribing it?

And I think that comes down to the fact that once these prescribing practices are in place for physicians it takes quite a bit of work to re-educate them. And I don't think it's in anyone's commercial interest to do so. And it's not really placed on any government regulator to do so. So while there's retributive justice I don't think we've had - we don't have any mechanisms for restorative justice when these kind of things take place.

Now, so that was - yes, my concern is that the commission may not be aware of these regulatory parameters and therefore how they may interrelate with some of the recommendations you've made. My concern is that the draft recommendations, particularly around the social wellbeing early childhood ones and some of the workforce ones may actually promote the practice of off label prescribing of psychiatric drugs amongst young children. Now that's not to say that that will happen but there very much is the potential

for that.

Now not only does such a practice have the potential to cause harm to these children and families but administering treatments which fail to have an evidence base for them is also wasteful to the Australian taxpayer dollars, the PBS already makes up a significant portion of the health budget, and it's only growing, and I think it's vital that resources are expended on evidence base therapeutic interventions. And then there's the consideration of what impact will this have on national productivity.

Yes, early intervention has the potential to enhance national GDP but not all early interventions are equal, access to interventions that lack an evidence base may actually do more harm to our national GDP. I think in my submission I also made reference to some figures that are highlighted in the draft report around the perceived trajectory profile of mental illness and that is that it begins early in life and tends to decline with age. But I think that's really important to keep in mind because it is very much in the commercial interest of industry to demonstrate that these products are safe and effective for use in infants, children, and adolescents.

And I think it would be naive to assume that just because they haven't been demonstrated to date that industry hasn't tried. So, yes, I think it's - I know some of the push backs that people may say well it's actually really hard to run these trials amongst the infant population and children, it's unethical, but I would sort of question well how much more unethical is it to therefore be giving it to them outside of trial circumstances without the evidence base. And I have seen some statistics which suggest that off label prescribing of these products is something that does happen in our country.

Yes, now I've covered a few more issues and provided a lot more detail about the concerns
- - -

PROF KING: In your submissions?

MS PILTZ: In my submissions. But I guess what I'm trying to stress is that good intentions are not a substitute for good evidence. But please don't take my word, I encourage you to talk to experts like Fiona Godley at the (indistinct) and she is across (indistinct) more than I am, and if you need someone locally I suggest Lisa Bero, she's recently moved to the University of Sydney from the University of California I think, and she's a global authority on industry influence in science. And she's a former Cochrane co-chair. Consult with these experts and I guess to understand a bit more about current regulatory parameters and how they make them and the potential they may have to actually enhance the rate of off label prescribing of these medications in Australia.

PROF KING: Okay, thank you for that. Your submission, and thank you, very much, for your submission, I certainly personally found it very valuable.

MS PILTZ: I'm glad you read it. And I can't tell you what it really says for me.

PROF KING: No, no, I believe you.

MS ABRAMSON: Hristina, we've absolutely both read it, although I did notice that a number of things are related to Stephen's previous life.

PROF KING: Related to Dr King in there.

MS PILTZ: His background, and - - -

MS ABRAMSON: No, we've both read it and it was a very well put together submission and it was easy to follow so thank you for that.

PROF KING: So it does tie very nicely into, if I can call it, a series of issues that have come relating to medicines in this inquiry. So as you know off label prescribing - well, sorry, I'll start at the other end. There is the issue of testing the randomised control trials the way that they're being conducted, and you would know probably better than I do that there have been issues raised about the efficacy of the approach used for randomised control trials, for example. But failed trials just disappear without note and successful trials obviously then get reported.

MS PILTZ: Yes.

PROF KING: Which means that overall if they're the same trialling for one drug it means that statistically the randomised control trials they did before that is not statistically valid. So there are all these statistical issues behind and they have been very well documented mainly in the psychological control trial space, as I understand, the inability to reproduce evidence.

MS PILTZ: Yes.

PROF KING: So I guess that's an underlying issue which is probably beyond this inquiry. But then at the next stage we are well aware of the off label prescribing that occurs for drugs that are related to mental health issues, for example, I think we get second highest in the world in terms of the percentage of population prescribing of antidepressants.

MS PILTZ: Yes.

PROF KING: Most of - well, no, I won't say most because I'm not because I'm not - 50 per cent, a substantive portion of which is off label. So generally, you know, and that's adults as well as children, so we're aware of off label prescribing being an issue. We're also aware of, you know, and this also reflects back on the pharmacy inquiry, GPs as well as specialists who simply can't keep up, if I can put it that way, with the latest research and the latest evidence on the medications that they may be prescribing and the risk that that creates to the community.

So we're aware of all of those. And I thought your submission in particular resonated as a

potential way that - I would like your feedback on whether we should be thinking this way, which is should we be thinking about recommendations that limit off label prescribing if not for a general population should they be limited for, for example, adolescents, or children under 12, should we be thinking about recommending to government prescriptions of off label prescribing?

MS PILTZ: I would say absolutely yes. I would say that if we were in America if you did that there would be a huge push back and I'd say yes do it but I don't think you would have any chance of doing it. I think you have a chance of doing it here in Australia because - I don't know how to put this without saying it too critically - there are lots of shootings in America that are happening and we only needed one to be able to as a population look at that and say actually that's not okay. But there are reasons why that can't be the case in America.

I think once there are enough people who are aware of the practice of off label prescribing of these medicines to adolescents when we don't have evidence of their effectiveness I think the most sensible course of action is to say, well, no, no, this isn't a safe practice for our children. So, yes, absolutely, and I think there's more chance of that getting through in Australia than there is in other markets. And I think it will send a really strong signal to other countries. We have a really - our PBA is looked at by other nations around the world and what we do in that regard people look to us and so I think that would be incredibly innovative in Australia to push something like that forward.

PROF KING: Christina, thank you, very much for that.

MS PILTZ: Yes. I don't know if I've said too much.

PROF KING: No, no.

MS ABRAMSON: It's okay, it's all been very helpful. Like I have to confess, I left some of the questioning to my colleague, Dr King, because I know with his pharmacy review background he was particularly interested.

MS PILTZ: Yes. I've actually - just so you're aware, I have contacted industry colleagues and I let them - the company that I used to work for, I contacted the head of their public affairs department before I made the submission because I have so much faith in the integrity and character of the people that I work with and I knew that I could do that in good faith and not get strong push backs because they're decent people and we always worked for making sure there was appropriate access to medicines, and the only feedback I got was good on you, that would have been tough to put together given your background so good on you, it's the right thing to do. So that's why I have faith in the fact that this is the right thing and we have an opportunity to do it here in Australia a lot more free-er than others do in other markets and I see no reason not to do it.

MS ABRAMSON: Thank you, very much.

PROF KING: Thanks, Christina.

MS PILTZ: Thank you.

PROF KING: Tea break, coffee break. Let's take a bit of a break, we're running a little bit late so if we can start again - it's not that late, if we can start again at 11.15 that would be fantastic.

ADJOURNED

[10.52 am]

RESUMED

[11.16 am]

MR SMITH: Hello, Stephen. Warwick Smith here.

PROF KING: Hello, Warwick. How are you?

MR SMITH: Good, thank you.

PROF KING: Now you've got myself and Julie Abramson here and - all ready to go with the transcript? All good? Yes. Now, so we are on transcript, because it's a public hearing, so if I could ask you, just first, Warwick, just so state your name, any organisation you're representing, if any, and any opening comments that you'd like to make. Warwick, are you there?

MR SMITH: Can you hear me?

MS ABRAMSON: Yes.

PROF KING: Now we can hear you, sorry.

MR SMITH: Okay. I think the microphone just dropped off, so I apologise for that.

PROF KING: No, no.

MR SMITH: Look, good morning. My name is Warwick Smith and I'm presently in Perth and I made a personal statement to the Productivity Commission. Now, can I just give a bit of a background and firstly start by acknowledging the lands we live on today, the Whadjuk people, the Noongar nation in Perth, and the Larrakia people, the traditional owners of the Darwin region. I pay my respect to elders past and present and the emerging leaders that we need for the future.

A bit about myself; I've been privileged to be a clinician, Allied Health, and have experience in working in paediatric, child, adolescent, youth, adult, older adult mental

health services. I've worked in in-patient and community settings and for both the Department of Health in Western Australia and for the community sector.

But I've mainly worked in leadership positions in Western Australia for the last 30 years. I was the Director of Richmond Fellowship in the late 1980s and have been a senior policy officer in the Department of Health and have been Clinical Director at CAMHS, Director and Operations Manager at PaRK Mental Health and I'm presently the Director of Youth Mental Health, Department of Health in Western Australia.

I've been a surveyor, now assessor, with the Australian Council of Healthcare Standards and I've been privileged to see Mental Healthy Services across Australia from 2007 to present in that capacity. I've had a passion for effective clinical governance, particularly how services use the voice of the consumer to improve services, the importance of integrated systems and the benefits of a focus on high quality service provision.

If it was okay, Stephen, from your end, I'd like to give a bit of the background to our contribution to the Productivity Commission to date and then some personal reflection, if that's okay with you?

PROF KING: Yes, although I would point out we have read your submission.

MR SMITH: Yes, okay. That's fine. And so I think - just going through, I think that Youth Mental Health made a number of submissions in April 2019 and also January 2020.

PROF KING: Yes.

MR SMITH: And provided a number of appendices in there and the one that we particularly chose were the reports for Mental Health Advisory Council for Western Australia, the submissions that we made last year about accommodation performance, knowing that housing is so important for our people with mental illness and I think when we reviewed your October draft report, we tried to provide some answers to the questions that you had in your draft report, which was very, very comprehensive.

The appendices that we gave were, I think, an article that we had published about the making of one of our public health services trying to be bicultural. They've got a really strong record of providing services to Aboriginal young people.

The Youth Wraparound was an article that we provided contemporary mental health services to a 15 year old child who had two thirds of their life in institutional care throughout prior to that and we made significant reforms in providing community services. The savings were significant and now that young person is going to TAFE, lives in a house, has friends and has a pet.

So I think they're some of the appendices that we provided to you. I think this morning I was just going to focus on a number of areas that were provided in the previous information and the first one was about integrated placement and support.

Now, I know that the Productivity Commission is really looking at the meaningful role that people can play in the future. I'm IPS trained. I went to Dartmouth in the USA and I visited a IPS psych in Lanchester and I've provided some information in my personal submissions.

And when I went to Manchester, which was in the USA - the population is about 170,000 people - there was ten IPS workers employed. What they found is that about 80 to 90 per cent of people with significant mental illness would like to be employed and they had significant outcomes. What they were trending about 85 per cent of people would get employment with the IPS model.

And when I spoke to your staff, who rang me back after I submitted my reply, I think it was really underestimated, the number of people that can benefit from IPS in Australia, who could be assisted into meaningful employment and meaningful education.

Since your staff member rang, we did an audit of one of our acute mental health services and we took away the number of young people who were employed. We actually found that for those that could benefit from supported employment IPS or supported education, it was 100 per cent of the remainder.

So we could actually take people with quite significant mental illness and support them into education and employment far, far better than what we have been doing presently in Australia, I think. And I think that was the comments I made in the submission. Professor Geoff Waghorn has reviewed the material I provided to you and he agreed with the information that was provided.

MS ABRAMSON: I think Professor Waghorn might have appeared in Perth at our hearings.

MR SMITH: I think it might have been Brisbane because actually - - -

MS ABRAMSON: Brisbane, yes, yes.

PROF KING: Brisbane. Yes.

MR SMITH: Yes, yes. Geoff said he made submissions, I think it was in Brisbane, and I have a lot of esteem for Geoff. He's gone to work in that area, so I had him actually review my data before I provided it to you.

The other one I think is the appendix in my letter and I think it's a personal reflection that even though that we were trying to mainstream with health services since the 1992 plan, it has not always been a good process for mental health services and I think there are many occasions where the budget for mental health services has actually been taken away.

You know, absolutely - there's a number of examples I've provided in the appendix where, you know, like 26 mental health services are told their budget will be quarantined and then 26 of them overheads are put on board. And we had a situation a few years ago in Perth where we'd reported that to the Mental Health Commissioner and it was trying to take away money to prop up mainstream health services and I think it's a significant issue in a number of jurisdictions, that they report that the money that has been dedicated to mental health is not always kept there and is often siphoned off.

And when we were trying to review, like we looked at the structure that you're looking at for the purchasing - there's a report by Murray Wright 2017 Chief Psychiatrist. I think he's made a number of really sound recommendations for good governance of mental health, particularly the recommendation three about accountability in governance, where he said that the Director of Mental Health should be a member of the district or network senior executive and report to the chief executive. And that may be some way, we hope, to look at some of the difficulties that mental health has had in trying to move ahead.

The other one to flag is the integrated systems of care. When I looked at the really exemplar services in Australia, these were lower North Shore in Sydney in the late 1980s and 1990s, Thalia and Warrnambool in Victoria, PaRK Mental Health WA and Youth Mental Health.

They've all operated in a continuum of care, from the schools or the GP through to the public sector, they've all seen that they were trying to provide an integrated system of care to support young people and families, but also support the GPs to provide better managed care and I think they've also focused on quality.

In Canada, there's a service called Foundry and it's worth reviewing. And they gave a presentation to an international youth mental health conference in Brisbane last year and Foundry becomes the front door. You know, young people go there; they're youth friendly, they're really appropriate.

But I think what is really important in Foundry is that there are 130 agencies that have signed up to the system of care through an MOU to ensure that young people and their families are assisted to the right service. And the integrated system includes cross-sector training, research and accreditation and that, I think, would be really worthwhile exploring for Australia.

Headspace were there, the national headspace office and they would have liked to have achieved the Foundry system of care approach in Australia, but they didn't do it; they weren't able to do that in Australia. And when I look at the services that get good feedback from GPs and schools, I think they really approach it in a systems of care approach.

PROF KING: Sorry, did - no, it's an unfair question. I was going to ask why did headspace think they couldn't achieve that in Australia, but that is really - that's a question we'll need for headspace, so apologies if I interrupted you.

MR SMITH: Yes, yes. No, I think it's - like, it's a really important questions. And it was like, at the forum that was in the International Youth Mental Health Conference in Brisbane and I chaired two headspace consortiums in WA and I've been involved in a number, trying to get them up and running, and I can tell you that that would have been, I think even now, a good way to continue.

PROF KING: So, sorry Warwick, because I interrupted, I may as well continue the interruption and then let you continue; so the Foundry model - and it's not one I'm familiar with, although there might be people on the team who are familiar with it - is it sort of a physical model where it then provides the access to services, is it a virtual doorway? Yes, a bit more detail?

MR SMITH: It's a physical place, but it's also virtual and people can contact them by phone and by, you know, social media, but I think the approach is that if they can deal with the front door end, but they've also got a number of 126 agencies beneath it that aren't all co-located and the model is much more about bringing the person and the family to the right place.

And I think - I don't know if your team are aware of the Toronto Navigation Project by Dr Anthony Levitt; he's been in Western Australia and Australia a number of times and they have a team of carers and a consultant psychiatrist.

Similar model; they're trying to link the person and the family to the right service and I think those are missing in Australian jurisdictions, where we focus on the organisation, to the exclusion of how do you help the service apply for young persons, the families, the adults to the right service model.

PROF KING: Yes. Which is different than a headspace approach, which is - and I don't want to downplay it, but I mean, it's more the young person goes in the front door and there are particular services there, but less of a linkage back into the broader community.

MR SMITH: Yes.

PROF KING: Yes, but it's different than a headspace approach, which is - and I don't want to downplay it, but I mean, it's more the young person goes in the front door and there are particular services there but less of a linkage back into broader community. At least, that's my impression. Your (indistinct), so.

MR SMITH: I'm the independent chair of the - two of the consortiums.

PROF KING: Yes.

MR SMITH: And I would absolutely agree with you, the focus is on the building as opposed to the (indistinct) assisted care model.

PROF KING: Sorry, Warwick, I interrupted you. So please, get - continue on.

MR SMITH: No, the areas – I’ve only got a few more, by the way, Stephen, so I think that was okay, and if you want to ask questions that’s fine. I think the other one that I don’t think comes strongly enough in your report is the development of people, and I think when you look at the (indistinct) services across Australia, the areas that they’ve done very, very well in is leadership development, and I think it’s more than just budget. It’s about how can leadership be thinking for the future, you know, models like John Kotter, really well. But I think the leadership for the future are going to be the leaders who can work across different domains, not just focus on the service that they’re running. I think they’re more management. But I think that the leadership that we really need to develop for the future is how to have leaders that integrate service delivery. So you’ve got Department of Education, you’ve got Housing, you’ve got Mental Health. All the social factors that we need and know make a difference. I think – the leadership development, I think, needs to be strengthened in the children’s mental health space, particularly that cross-sector approach, I think, was really important and really, how to emphasise the quality for young people, and the other one is the development of staff.

I think that is the area that in my experience, in 30 years – if you’re really investing your staff in contemporary roles that are client-focused, you’ll really get wonderful results. Probably a couple of years ago, I was awarded the co-winner of the Exceptional Contributions to Mental Health Service in Australia and New Zealand, about 2000 and, I think, 18, and funnily enough, when I think about my career, the things I tapped into the most is, I was in – before I started in mental health, I was actually on the national team for white-water canoeing. I went to world championships around the world and I got coached by a – one of the best coaches in the world, and then I became a coach and so I’ve become a coach at state and national, and my athletes have got medals at Olympics and at white-water championships, and I think, for me, bringing that preparatory development for our staff, whether they’re peer support or professional, I think has made a difference in the services I’ve managed, and so it’s past in use. It has extraordinary results from clients and consumers and they’ve won many, many awards, and I think they’ve focused on really good service elements that are important, and sometimes I would tell my clinicians, you know, provide a service as if it’s your mother, your father, your grandfather, your brother, your sister, your son, your daughter, and so they really understood that they were out there every day to provide a high quality service to people who had come to see them, and I think that could be strengthened in the report.

The last part, I think, is our lack of implementation, and Australia is world-class in having wonderful planned mental health. But we do not do well in the implementation of the plans or consistently resource the services that are needed by people that are experiencing mental health distress or illness. My reflections were that the national plan in the early ’90s – 1990s achieved reforms across Australia. As (indistinct) Australia’s state level, the reform by (indistinct) purists, in 1996 through the Liberal government and then by Tim McKinney later in 2004, achieved reform in mental health. You could feel it. Staff, consumers, carers could see the reform that was being done and they could actually see the positive changes. What the consumers, carers and staff experiencing – about the reform in – principally in Western Australia is that it’s lacking. We had a wonderful mental health plan for 2015 to

2025 which is an excellent plan. The plan has been well-researched and consulted widely. It has many important actions for children, adolescents and young people, 2015 to 2025, that would significantly improve the health and wellbeing of children, young people, their families and our communities.

Unfortunately, it's close to five years since Mental Health Change was launched. Very few of the actions have been implemented for children, adolescents and young people. The majority of actions have not had the work undertaken to progress, and that was - the Auditor General of Western Australia identified the lack of implementation plan in Western Australia and I think we have to really be aware that that is a factor, is - how you're going to plan that implementation is really, really important.

PROF KING: Can I ask you - just related to that – you brought the Auditor General up and I note in your submission that as I understand your view of the two options, the rebuild or the renovate model, that the rebuild is the preferred model. It doesn't take a genius to work out that we got the idea from the WA Mental Health Commission model and that was our starting point, but the Auditor General's recent report – I think it was December, it might have been – into the WA Mental Health Commission and how it was progressing in terms of rebalancing services was very negative, or at least my reading of it was very negative. It basically said, well, you know, it was meant to rebalance towards community services. It's been singularly ineffective at doing that. Any thought on that? Because you suggest you prefer or you state you prefer the rebuild model, but we're wondering why, in a sense, what we expected to see in WA hasn't occurred, and is that due to implementation? What's gone wrong?

MR SMITH: My personal reflections would be that we've had a state – the previous government launched the mental health plan and we had a period of time in WA with a (indistinct). But I think at a government level, mental health does not have an agenda that is given significance. If we've created a (indistinct), we've put \$1.4b into the Optus Stadium for football. We've had a – Graylands Hospital has been - from the 1992 mental health plan, there've been plans to move it to a mainstream health services hospital, and they still haven't done it. So probably, they have not invested the money to move Graylands into a contemporary service and I think that is reflective of how the state government presently is viewing mental health. They haven't done it, and so what you have is a lack of action at a state government level and the mental health condition is not seen as a beleaguered area to reform. All the actions and - for children, adolescents and young people haven't been enacted. Absolutely have not been enacted. So what the young people (indistinct) services that were really awesome have not been provided, and particularly in areas throughout Western Australia where eating disorders, young people from a friendly background – and we've also got a crisis and assessment team that's been planned for Perth – none of these really important areas have been implemented. So what you have is the number of plans abounding for about 15 to 20 years and a lack of implementation.

PROF KING: All right. Thank you very much for that, Warwick. Did you have any - -

MS ABRAMSON: No, no questions, thank you.

PROF KING: No, all right. Thank you very much for your input here today.

MR SMITH: Could I make one more statement, by the way?

PROF KING: Yes, please.

MR SMITH: Okay. I think – to be honest, I think the other one when it comes to productivity for Australia is about the blueprint mental health reform needs to be longer. I think in my personal statement I said it needs to be 2020 to 2070. I think because the issues are intergenerational, if we only stick to three- to four-year time periods, we won't achieve it and I think the true approach is going to be the true leadership. I think the productivity report has been really fantastic in the work that you've done and you should have thanks to your team as well for the work that they've done, but I think it's going to take the federal and state and local council true leadership to bring that together and implement the recommendations of your report in a meaningful way, and I think that would really make a significant improvement to mental health across our nation. So I just wanted to say thank you for the work that you're doing and I really look forward to the implementation of the productivity report. So thank you very much.

MS ABRAMSON: Thank you.

PROF KING: Thank you, Warwick.

PROF SHEFFIELD: Hello?

PROF KING: Hi, is that Les?

PROF SHEFFIELD: Yes, this is Les, and I've got Allan and Sam Mostafa with me.

PROF KING: Excellent. And at this end you've got Stephen King and Julie Abramson from the Productivity Commission. So, this is a public hearing so you're being recorded on transcript. So if you wouldn't mind after just introducing people, if you wouldn't mind re-introducing your team, your organisation, state your organisation and any opening comments that you would like to make, please.

MR ALLAN SHEFFIELD: Yes, thank you. And can you hear me okay?

MS ABRAMSON: Yes.

PROF KING: We can hear you perfectly, yes.

PROF SHEFFIELD: So my name is Professor Len Sheffield, I'm a clinical geneticist. I have with me my son, Allan Sheffield, who is one of the directors of our business. I also have our clinical director, Mr Sam Mostafa, who is a (indistinct).

PROF KING: Excellent.

PROF SHEFFIELD: And our company is myDNA. We're a genetic testing company and we specifically started and one of the main things we do is genetic testing for medication, to match people's genes up with their medications.

PROF KING: All right.

PROF SHEFFIELD: So I'll start off with a brief introduction. You've heard I'm a clinical geneticist. I've been involved from the very beginning with my lecture Genetic Care, and I've helped introduce several new tests to the drug market and to the health area. I've worked most of my career in the government service, then joined the clinical and genetic service. And for the last 12 years I've been working for my company, myDNA, which was really formed because I found this new area that wasn't being provided by the (indistinct), and we've done and we continue to provide (indistinct). (Indistinct words) have become much more into the mainstream and I'll tell you what (indistinct), and is now available through all the major pathology. But the test matches people's genes with their medication. And so we've provided in our application a solution to help people who have depression because one of the major treatments of depression is medication. The problem within the medication is that it's got quite a high rate in which the medication is not the right one for the person and it doesn't work. That's up to 50 per cent. And then quite a bit of guesswork in trying to get the next best answer. People need to be on the first one for several weeks and then they will go on to another one that takes four. There is no, except for our tests, there's no sort of physical test like taking somebody's blood pressure in order to say how they're going. It's really a trial and error and are you physically better, and the test results are better. And, as you know, the question can lead to suicide, incapacity, it's a long hospitalisation for many months.

MS ABRAMSON: Just on that though, - - -

PROF KING: Yes, we've read your submission and recognise the importance of matching the individual to the particular antidepressant, for effectiveness of the antidepressant. But one of these - and apologies if I missed it - but we do of course know that antidepressants can have significant side effects and proven suicidal ideation. To what degree is the correct match of the antidepressant relate to those side effects? So I was just wondering, if you - so is it a correct match; not just that the medication is working, that also reduces the side effects?

PROF SHEFFIELD: Yes, absolutely. So, what we're looking at basically is how far the (indistinct) is focused in the (indistinct).

PROF KING: Okay, yes.

PROF SHEFFIELD: Because people vary tremendously. So if the medicine is taken too slowly, for the person who is on a standard dosage every day they will end up with too high a blood level.

PROF KING: Yes.

PROF SHEFFIELD: And we know that blood level has been linked to side effects. And in particular there's something that has only recently been found, it's in the - very well published in the psychiatric literature, the higher the blood level the more side effects there are. And this is one of the major things that the (indistinct words) in any (indistinct). Equally, if it's too fast then the duct may not have (indistinct). And what's been shown that if people are what's called 'ultrarapid metabolisers', very fast metabolisers, then the link with suicide, a greater risk of suicide, and the faster it goes the greater the risk of suicide. So, in both of those situations the (indistinct) genetics can help, the (indistinct) or (indistinct). And not only can they tell the risk of suicide or some of these side effects or when the drug is suitable, but that very thing that when the drug is suitable is that if the first thing the test showed that drug A is not suitable but then the test would actually recommend which ones would be. One of the reasons we think the time is now is that when we started this ten years ago we - that's one of the first principles on what to recommend. We're now international recommendation (indistinct), so that we say that if you're on drug A and you're genetically (indistinct) for B, then the international recommends you should do whatever that recommendation is, and we would print that in the report so the doctor can follow it. So invariably what the doctor wants to know is how is this drug for and what shall I do with it?

PROF KING: Okay.

PROF SHEFFIELD: So that's the basic reason to do it, but we've seen some remarkable changes in people who have gone through this cycle of them not being on the right drug, having terrible side effects, perhaps getting terribly agitated, taking risks or attempted suicide, to ones that have the test, another drug administered and within a few days to weeks they become normal and they have changed dramatically. And we've seen this pattern over and over, it's wonderful and so important (indistinct). Now, - - -

PROF KING: I understand your drug is not covered by the Pharmaceutical Benefits Scheme - or your test is not covered, I should say, by the Pharmaceutical Benefits Scheme at the moment?

PROF SHEFFIELD: No, it isn't. It doesn't have a rebate at the moment for the MBS, the Medical Benefits Scheme. There are some tests that are covered by the Pharmaceutical Benefits for very expensive drugs, they're mainly cancer drugs, but (indistinct words) up.

MS ABRAMSON: Can I ask; are any of the private health insurers able to cover the cost? Normally (indistinct) follow MBS, are there any of the tests that are being paid for by the private health insurers?

PROF SHEFFIELD: Not in Australia, but recently there's been quite a sting of activity in the United States where (indistinct) insurers have taken this up and they can't recommend or (indistinct words) genetics.

MS ABRAMSON: Thank you.

MR ALLAN SHEFFIELD: I might just add to that. It's Allan here. That we accept that United Healthcare, who are the largest health insurer in the US, have recently funded this very area that we're putting our proposal. And in Australia we're met with all the - most of the major health insurers and their chief medical officers, and their view is that it's a pathology test, therefore it's a government issue, not a healthcare - not an issue under insurance. So it sort of got blocked at that time when they sort of pushed it back to government.

PROF KING: Okay, and that answers my next question. So it's – so from the perspective of the health system in Australia, it would be classified as a pathology test and therefore whether it would be covered under MBS or not – okay.

PROF SHEFFIELD: Yes. So we're also aware – and I'm aware of - having been resolved in a couple of tests - that it's gone through the wrong branch to get the Medicare benefits, or MBS benefits. So it takes quite a few years and you have to battle against the fact that they would rather fund just some drugs, or some situations, whilst what we're saying is that everyone who has these sort of drugs would be better off (indistinct).

PROF KING: Yes.

MR ALLAN SHEFFIELD: And that, you know – and it would be worse to say – and I think Les was touching on it – but you know, this year, there's been through the Royal College of Pathologists, a positioning paper which is basically defrauding this type of testing and I guess part of our intent with this proposal to the productivity commission is to say there are real benefits that can happen today that should be considered as opposed to going through a longer, drawn-out process through the typical pathways.

PROF SHEFFIELD: What we say today – I'll just, very briefly – it's now – in the past, people would look at these doctors because the viewers said, well, where are the randomised control clusters? There are now seven randomised control clusters. The next question is where is the cost benefit? There are now four or five cost benefit studies that show significant costs savings for those people who had pharmacogenetic-guided treatment and as I mentioned before, we now have the international recommendations. So the time is now to be able to acquire this.

PROF KING: Yes. So – and I note in your submission you make a specific request, obviously, for your particular pharmogenomic treatment. I guess from our perspective, we wouldn't be making a recommendation for a particular one, simply because that wouldn't be appropriate. We're not clinicians and also, we haven't done a full review of all the

possible pharmogenomic treatments that are available. So I guess what I'd like to ask is -
- -

PROF SHEFFIELD: Can I just direct you in terms of – whilst we have represented it as our company and we know ours is best, (indistinct) now all the major pathology companies are providing this in Australia, and so that we are not pushing towards just us getting this testing.

PROF KING: No, I understand.

PROF SHEFFIELD: It will be available for routine pathology.

PROF KING: Yes. So – yes, but I guess my question is, what – we could make, you know – in terms of pharmogenomics as a group of approaches to improving the efficacy of medication in mental health, what needs fixing? What can we recommend at the government end? Is it that – is the problem that these tests come under – are classified as pathology tests, so there is only a long drawn-out process to get them listed? Would it be better if they were treated in the same way as medicines are treated, so going through PVAC to get listing on the PBS? How can we improve the system? Because in a sense, we will be making recommendations to the government about how the system can be improved. So how can we improve the listing system for these sort of tests? Recognising that, you know, from my own background and the pharmacy inquiry I did a few years ago, everybody knows pharmogenomics is coming down the track and it's going to be a huge benefit to consumers, but no one's quite sure of how it fits in our current system.

MR ALLAN SHEFFIELD: Yes. I mean, I think that you've hit the nail on the head in terms of, it's really stuck between the MSAC and the PBS, sort of, process and therefore, it's - you know, traditionally it's going to get caught up in not really having a way to sort of drive it through to be, you know, it might – as a, you know – I guess as a top priority, sort of, pushed through as something that can be – gain significant efficiencies in mental health, and there needs to be a more streamlined process that international – and guidelines that are, you know, support – or making it more transparent that this testing is now available, elsewhere in the world it's being reimbursed by health insurers and, you know, I suppose we need a bit of process to fast-track it through the government system.

PROF KING: Yes.

MR ALLAN SHEFFIELD: And you know, traditionally, there's obviously benefits on the PBS but there's also benefits – or MSAC, but ultimately in the middle is the patient who's going through months and months of trial and error and, you know, we've spent the last 10 years enabling all the major pathology companies so they now have a service to offer, and ultimately the barrier from the doctor is education and then also cost. So part of what we're proposing is why don't take a hard-to-treat group like, you know, youth mental health, or even, we've been discussing, with some of the recent, I guess, policies around veterans, because in the US, the – since 2014, they have covered the costs for veterans in the US for this type of testing. So say let's take one big group that we can make a big

impact and showcase how it can really make such a tremendous benefit and then maybe make it more broadly available to everybody.

MS ABRAMSON: It's Julie. Can I come back to the private health insurers? Because one of our recommendations is that we would like any restrictions on the private health insurers providing support in the community to be dealt with in the way that they now provide oncology services in the community. So couldn't you have a situation that they can provide – the health insurers can do more in community supporting people in their homes, and at the same time, they would be able to send – to pay for the tests in terms of the efficacy of the drugs. So from our perspective, subject to any actual limitations on that, that's the kind of proposal that could sit quite well with our – letting the insurers do more in the community.

MR ALLAN SHEFFIELD: Yes, I think – I mean, I think that would be a good recommendation. It just, I guess, needs to be – if it's packaged up as part of the home care or as part of the overall service as opposed to purely a diagnostic test - - -

MS ABRAMSON: Yes, that's right. I mean, I think we're very cautious, of course, as you know, about a further cost to the PBS which is, I think, one of the largest costs of the Commonwealth government in this space. So we can have a think about that in the context of the private health insurers, but it would be aligned with their ability to provide services in the community. So I want to have a think about that.

MR ALLAN SHEFFIELD: Yes, and certainly our feedback from GPs and specialists is if it was funded by the health insurers, they would be recommending it to every one of their patients. So there seems to be support. It's just dealing with some of that cost barrier, and it doesn't even necessarily need to be subsidised 100 per cent. It's just the fact that, you know, if you get some of this back through your health insurer, you know, it would mean that it would be much – a far greater uptake by the doctors in their confidence to refer the test and make it accessible to their patients.

MS ABRAMSON: Well, I just think it's kind of an interesting proposition – and now, I'm just having a conversation, to be honest. We're having a look at this, because after all, health insurers do fund a whole range of complimentary therapies in the community. So we'll have a think about it.

PROF KING: Okay.

MR ALLAN SHEFFIELD: Yes. As I said, the feedback that we've had from the medical directive – we've seen – it's sort of been pushing it back to government. So we need to be creative. We have - as Les mentioned, though, we do have, you know, testing for certain drugs servicing childhood leukaemia and oncology where the MBS has basically funded the testing, and the second issue that – or second point is that when we started this journey 10 years ago, the test was hundreds of dollars. You know, at scale, this test is, you know - it would be under \$100 and it's a once-in-a-lifetime test. So you have to do it once and then you've got that information. So yes, one of our points was, well, we think the cost is

now at a point where it's affordable compared to some of these other costs that the health insurers are funding for these programs, the mental health programs, the GP – the price is there and the evidence and the accessibility to pathology. So we think the three of those make it – the timing's good.

MS ABRAMSON: Yes, yes. No, I understand. Thank you.

PROF KING: Thank you very much.

PROF SHEFFIELD: You're welcome. You might be interested, in one of the randomised control trials were the people who were being discharged from hospital to home care and the group that has to go to (indistinct) as part of the going home package, they stayed at home and stayed out of coming back into hospital at a higher rate than the people who didn't.

MS ABRAMSON: Can you send - you would have some contact details for our staff, because I know they've been talking to you - could you send that information through? That would be very interesting.

PROF KING: Yes, if you've got a link to that - the publication that's listed in the RCT, that would be great.

MS ABRAMSON: Yes. Yes.

PROF SHEFFIELD: Yes, I'll send that to, I think, Erin.

MS ABRAMSON: Yes. Yes, yes, yes. Thank you so much.

PROF KING: All right. Thank you very much Les.

MS ABRAMSON: Thank you.

PROF SHEFFIELD: Thanks very much for your time.

PROF KING: Okay. Sorry, we're running late.

MS KRETSCHMANN: Hello, Tanya speaking.

PROF KING: Hello, Tanya. Stephen King and Julie Abramson from the Productivity Commission.

MS KRETSCHMANN: Hello, how are you?

PROF KING: Not too bad. We've got a very strong buzz coming through on the line. Are you on speaker or - - -

MS KRETSCHMANN: No, just let me find the cord.

MS ABRAMSON: We might try ringing you back, sorry.

PROF KING: Yes. I'll actually just try ringing again, if you don't mind?

MS KRETSCHMANN: Yes, that sounds great. Thank you.

PROF KING: All right. Give you a ring in 30. Thanks.

MS KRETSCHMANN: Hello, Tanya speaking.

PROF KING: Hello, Tanya. Yes, still got the - yes, the same. Is that okay for the transcript?

MS ABRAMSON: Yes, well, that should be - - -

PROF KING: Yes, we're getting a nod off the transcript person, so we'll persevere. That's the main thing. Tanya, if you could just introduce yourself? Any organisation to represent, if any, for the transcript and then any introductory comments you'd like to make?

MS KRETSCHMANN: Absolutely, so my name is Tanya Kretschmann and I have a lived and living experience of mental health concerns and suicide, so therefore I'm not necessarily representing any organisation, but I'm representing myself as someone with a lived experience and also using the foundational knowledge that I have based on the representative and advocacy roles that I have at local, state and national levels.

PROF KING: That's brilliant.

MS KRETSCHMANN: In terms of opening comments, I guess there's a couple of things that I just wanted to touch base on today that I thought were either not necessarily thoroughly covered in the draft report or were potentially missing elements.

The first thing is the medical model and speaking to shared perspectives on balancing that with psychosocial models or more personalised care models. The second area of interest that I'm hoping to share is addressing the translational research gap for mental health and also evidence-based practice that then builds the foundation of our typically public health system.

PROF KING: Yes.

MS KRETSCHMANN: The third area of interest is early intervention, so looking more - aside from the prevention, but including some of the gaps that I see in the early intervention organisation. And then finally and very, very briefly just around the systemic acid you see the component and particularly around some of the fundamental infrastructure that we see in order to implement some of the recommendations.

MS ABRAMSON: Tanya, one thing - it's Julie Abramson - that I would say is that we understood that how our draft report came across looked like we thought that the clinical model was at the centre of everything. It's actually not what we were thinking, but we understand why stakeholders would have formed that view, so we're really interested in having that conversation about psychosocial supports.

MS KRETSCHMANN: I see. Yes, I think I - yes, and I could absolutely see that there was an interest in broadening the lens of health and particularly coordinating across government to really addressing the psychosocial determinants of health and you could see obviously from the psychosocial models that were being adjusted to the medical treatment, I think those are still obviously an element of trying to broaden our conception of health and wellbeing and what our - how we conceive treatment to be, broadening that lens beyond the health sector, which brings its own concerns, but also then it seeks to potentially adopt both physical and mental health approaches rather than simply trying to address our mental health approach in isolation, which I think then further - if we're just addressing our mental health approach in isolation, further compounds the struggle that we have in broadening the supports that we need to receive in order to maintain mental wellbeing.

And so for me, I think it's just necessarily highlighting the personalised or universal personalised care approaches that seek to really equate not just social describing, which I know was raised, but really equate community-based supports in alignment to medical models to hopefully then empower those systems to support and reduce some of the burden on our medical based care.

And I think one of the things that stuck out to me, which I think then limits the ability to adopt those process, is utilising the stepped model of care as the primary model to orientate health services.

My lived experience of stepped model of care has been potentially climb up the stairs or coming down those stairs and I think naturally the steps approach naturally and inherently help implement a threshold-based system and when we've got a threshold-based system, particularly in the generic-based environment, then we'd pop that to the extremity, which means they aren't necessarily ever getting a matched level of care in that stepped care based model.

PROF KING: Just on that, so there's a couple of issues from there. So there's two. One we're certainly grappling with, which is how to make it quite clear that, in a sense, psychosocial steps and the clinical steps are separate and so - a simple example; someone with high psychosocial requirements may not be the same as someone with high clinical requirements at any point in time, so the example I've been using is someone - a real life example; someone with hoarding disorder who needed significant housing support, but they were able to hold down their job, were performing fine in most aspects of their life, but they were about to lose their house because it had been deemed a fire risk because of their hoarding and you couldn't access doors and things like that, so we're trying to capture that element, but you know, it's not just a one-size-fits-all sort of step up and down.

But I also want to touch on the other point that you just raised there, which is you tend to get pulled to the edges in such a system. How do we make sure that we avoid that, that we get the services in the middle? And I don't want to use the term 'missing middle' but I will anyway, because everyone else uses it, but in that area where so many services are currently missing?

MS KRETSCHMANN: Well, I think the struggle that we currently have is when we've defined these steps, we've really defined the bounds in which those services can step into and out of, and I think the difficulty there is - I think one of the challenges of potential is one the opportunity is by opening the doors that exist on these steps to allow services to respond across the steps, the steps that are most appropriate, and therefore meet the consumer's needs.

Because I think unfortunately at the moment here, and looking at high intensity or even complex care, the services that can provide that support in those particular streams are constrained to those streams, so potentially can't be responsive and I think that's what I see as the flaw in the stepped model.

Absolutely not a flaw in conceptualisation, they're saying that we need to be able to have a matched care system that has meaning for the care requirements. But when we define those levels we essentially put those doors in place, not just for consumers but for flexibility and services and how and where they can step to respond.

MS ABRAMSON: It's Julie, Tanya, one of the issues is, and Stephen has made this point on a number of occasions, how we design that psycho/social system, if you like to call it that, because at the moment so many services are only available on the basis of a diagnosis, so one of our issues is that in the report we could see where the gaps are in the clinical system and so we could go about thinking well this is what we need to do, but when we looked at psycho/social there were so many different programs that were funded, unfunded and we struggled quite a lot trying to bring a unity to that. So one of our issues is how we would make supports of - in a resource constraint world we would make resources available for people in psycho/social supports, so we're quite interested in what you were just talking about, matching care, do you have some ideas on that?

MS KRETSCHMANN: I think there's piggybacking on what else was happening internationally but I think, for example, the NHS in 2019 released the universal personalised care model, which exists across both the physical health and mental health sector and that seems to work in quadrants rather than in scale but for me that tends to encapsulate then the equation of both clinical and non-clinical services that then facilitate the funding part. I think the reason we've seen so many ad hoc social psycho/social supports that are in and how varied they are in their funding sources is because they haven't been emphasised or even prioritised in their position in providing and supporting wellbeing, which means they haven't been consistently re-funded. And I think it's not until we re-imagine medical and psycho/social supports being equatable supports than just variable depending on an individual's circumstances that we're ever going to see the funding

industries that can create that sustainability that can then match demand which can then take the pressure off the clinical. And I don't think we're going to do that until we start to actually approach the conceptualisation of health care. We're only talking in the mental health ones and we're already putting boundaries on it and then I think we're not even looking at how we will conceptualise it. After all we have poor health and across inter-sector governments and then we are again constraining how we can see it.

MS ABRAMSON: Thank you. Tanya, could I also ask you about you've got a point you've accessed any consumer advocacy structures, what does that look like from your perspective?

MS KRETSCHMANN: I guess that's actually what I wanted to touch on a little bit briefly, I can see the recommends things with around just monitoring and reporting on systemic advocacy. I think for me I'm just very acutely aware that within Queensland and the Northern Territory, between jurisdictions that we don't have peak bodies to really support systemic advocacies and the collation of voices to create impact.

And I think for me what we absolutely need to also look at how we're supporting the consistency and collation of a voice at a national level. I don't think really we can do that until we support the equity of our states and territories to have a voice. And I think particularly in the Northern Territory and Queensland we don't have mechanisms to support systemic advocacies by consumers and carers then already we're at a step – at a disadvantage before we can even step into the national sector.

MS ABRAMSON: Could I just ask you one point on that because I think in Victoria, the State Victorian Government has funded some of that advocacy and certainly all of the states have mental health commissions in various forms, you know, that they're not all the same, the West Australian one is a commissioning model, looking at the Australian - and I will get you to state on the record, but I'm thinking of as a Victorian, to be honest, so do you still see that as - and I'm not being negative about this but do you still see that as a Commonwealth responsibility not something that the states would have a responsibility for?

MS KRETSCHMANN: To be honest I think it's a shared responsibility. I think absolutely at the national peak perspective which is where you're looking at the national agenda, but I think at the Commonwealth we absolutely need to respect that if the states aren't necessarily able to support those agendas then we're at a disadvantage at the national level when those workers aren't heard. And I think until we can support equity of those voices then we're going to continue to see funding and even resources being distributed to where our voice is the loudest and that's not necessarily voices that we're always meant to hear.

MS ABRAMSON: No, that's been very helpful, thank you.

PROF KING: One of the other areas you wanted to touch on was early intervention so which particular issues there would you be wanting to discuss?

MS KRETSCHMANN: For me I think it's - I had the beauty of being able to work in some of our acute services and also community based services in the public health system and I was just absolutely aware that obviously 75 per cent of those who develop mental illness do so before they're 25 years of age. And so for me I've got a particular interest in how we support individuals who have been identified that they're a health concern, particularly in the early developmental years when we can impact on prognoses much greater in those early years of diagnosis than in later years.

And I think at the moment what we have a particular awareness of is that particularly to individuals say 17 years of age to 25 years of age who have entered the adult system, you know, already in a burdened acute adult system that we're not necessarily - we're not meeting the treatment as sensitively as - of all the therapeutic interventions of those individuals because of the demands that exist on the system and the model of the system that exists within adult services.

And I think we're going to try and look at how we assess the due demand to then be able to support the reallocation of resources from our two centres to our prevention sector. But I think one of the key populations that we can do that with is individuals who have an early onset of diagnosis and particularly in those developmental years up to 25 years of age, we the system supports appropriately and adequately won't go on to have enduring illnesses and I think in the existing adult acute systems we don't have the capability of giving the appropriate treatment or even the appropriate dosages to support that recovery.

PROF KING: So in some ways headspace is one of the approaches that's been taken in that area, and headspace is 12 to 25 years of age?

MS KRETSCHMANN: Yes.

PROF KING: Yes, I couldn't remember if it was 14 or 12. Any thoughts on whether that's an effective intervention, should there be more headspace centres or are you thinking - what are you thinking of there, Tanya?

MS KRETSCHMANN: To be honest I'm thinking - I think the legal thing of headspace is an alternate concern, I think from my perspective is we're seeing too much of a demand on our public health services for up to 25, which means that our headspaces have catered to the more moderate to severe end when they were primarily or originally developed for that low to moderate mental health concerns end of the spectrum.

I think there's a whole other band of concern that fits to their effectiveness there, but I think for me it's potentially the development of transitional services for the acute sector to appropriately respond to those individuals. Because I think at the moment individuals who have an acute presentation, which many do, under the age of 25, aren't necessarily well supported in our community care so they are popped into our all youth services but then all adult services are not necessarily supported there.

So I think absolutely headspace does a remarkable job for the community sector but I think

the group of cohorts that I'm particularly concerned about is those who are above that threshold for headspace but who absolutely are falling short to receiving appropriate care in our adult acute system.

PROF KING: Yes, and the issue of things like child and adolescent beds in public hospitals even, yes, so the gaps in the system there.

MS KRETSCHMANN: Yes, or even not necessarily being across the board, our services not being able to provide therapeutic intervention and so that missed opportunity of being able to really get in early and have an impact on development.

PROF KING: Thank you for that.

MS ABRAMSON: You've been incredibly helpful. Really, we'll have a good think about some of the things that you've said today, so thank you so much for making time available for us.

MS KRETSCHMANN: Thank you, and I guess – I think the only thing that I really wanted to, I guess, hit home about is, yes, our translational research gap on any individual who didn't get onto our service line (indistinct) treatment, and unfortunately, there's a 17-year turnaround. I don't want to wait another 17 years to find out my (indistinct) chance of recovery, and so for me, I think, underpinning what is ultimately delivered to (indistinct) and carers, if we can improve the efficiency with which we can get it into our hands to be tried, to be tested and to include that whole of your life, the better outcomes start, I think. Ultimately, at the end of the day, that's really interesting, our translational research, and I don't necessarily feel as if that's being picked up in the other court.

MS ABRAMSON: No, we'll have a think. Thank you so much for your evidence today.

PROF KING: Thank you.

MS ABRAMSON: Thank you. Bye.

PROF KING: And if you could just state your names and your organisation, and any comments you would like to make for the transcript, and Matt is bringing water.

MS HARRIS: Is this okay here?

PROF KING: Yes. They're just for the transcript, so if you can speak up.

MS HARRIS: Yes, okay. My name's Vanessa Harris and I'm the executive officer for the Northern Territory Mental Health Coalition.

MS DAVIS: And I'm Judy Davis. I'm the chair of the board of the Northern Territory Mental Health Coalition.

MS HARRIS: Yes. We've just prepared a statement because there's been a lot we've written in the April submission we wrote and we've just responded.

MS DAVIS: And we've read yours, of course.

MS HARRIS: Yes, and we've responded to the draft one that's just – that closed in late January. I think one of the couple of points we just want to make listening to some of the interesting information that you're gathering from other people was that we actually don't have a mental health commission here in the Northern Territory at all and we actually don't have an independent chief psychiatrist advising the health minister here or the Northern Territory Department of Health. So that's been a bit of a lag for us and it's been over two years, I think maybe longer. But it's been quite a hindrance for us in the community mental health sector. So I've got a bit of a statement with me.

PROF KING: Sorry, just on that point - - -

MS HARRIS: Yes?

PROF KING: Do you mean it's been over two years – so the – is it the (indistinct) of chief psychiatrists but it hasn't been filled for two years? What's the - - -

MS HARRIS: They're restructuring.

PROF KING: Okay, yes.

MS ABRAMSON: And could I just ask on the mental health commission, is the – and my apologies for - - -

MS HARRIS: That's all right.

MS ABRAMSON: - - - because I'm sure somebody will have told me that at some stage – is there nothing within the health department itself? Because not everybody has standalone mental health commissions. So is there no kind of – nothing?

MS HARRIS: No. There's nothing here in the NT.

MS ABRAMSON: Thanks.

MS HARRIS: So – and that independence around that advising is not here for us.

MS ABRAMSON: Yes. No, I understand.

MS HARRIS: So Peggy Brown was very good for five minutes and then Denise – Dr Denise Riordan came for a little bit longer, and then we haven't had anybody, and we want people who sit outside the tent.

MS ABRAMSON: No, I understand that.

MS HARRIS: We don't want them to be a pay packet from the NT health department because that's not an advisor. That's an employee.

MS ABRAMSON: No, we understand that. It was more - understand that there actually wasn't something.

MS HARRIS: No, there's nothing.

MS ABRAMSON: Thank you. This is why we do our original visit, by the way.

MS DAVIS: And I guess we're speaking from the NT context today and representing the needs of this jurisdiction.

MS ABRAMSON: Yes, absolutely.

MS HARRIS: So I suppose a little bit about us is that we're the peak body for community-managed mental health services here across the Northern Territory. One of the things - when the Commission said we were going to the inquiry, we contacted a whole lot of organisations in January last year - the legal services, housing, the Aboriginal community-controlled, AMPs and the peak - and we gathered everybody together for a bit of a meeting to see how we'd write. I think this was a really good opportunity when the mental health commission opened this up to social determinants because there wasn't really a voice around the legal - how people who are unwell are intersecting with the courts, it's not really clear, the mental health that impacts on housing - so this was a really great opportunity and I commend you for opening up to the social determinant mental health in January 2019.

So I think a little bit about us is our vision was for all Territorians to have the opportunity for the best possible health and wellbeing. Some of - the purposes we have is a strong voice for mental health and wellbeing in the Northern Territory. The Coalition welcomes this opportunity to contribute to the Productivities inquiry into the social and economic benefits of improving mental health. We support the Commission's view that there are many factors in addition to mental health service that can improve mental health and lead to greater economic participation, enhance productivity and economic growth. As the peak for - the body for Northern Territory community mental health, the focus of our submission was to highlight the diverse populations, the vast distances, the thin economic markets and the complexities inherent in delivering adequate appropriate services in such an environment.

The complexities - the Coalition seeks to facilitate an accredited and supported mental health system across the Northern Territory where community mental health is available for all Territorians. That encompasses the full spectrum of prevention, early intervention, treatment in people's local area and in their towns with low and no barrier to access. So what we're also asking is that it is fully integrated with other services that may be available as well staffed by trade-knowledgeable people, including peer workers, at times of the

day/week/year when support is most needed, and we also ask that in a culturally safe, respectful manner inclusive of participants' families and their communities, and that demonstrates long-term trust, consistency and commitment, which we haven't had in the Northern Territory around mental health for a very long time.

The Northern Territory, sort of, context of how we are working here is that there's a range of complexities – interrelated factors that impact on accessibility and quantity of mental health services in rural, remote in the Northern Territory. However, the accessibility and quality of mental health services cannot be considered in isolation from the specific social/economic disadvantage and intergenerational trauma experiences by many Aboriginal and Torres Strait Islander communities in the NT. Social/economic factors that contribute to the significant burden of poor mental health in this population include overcrowding, poorly maintained housing, high burden of chronic disease, high levels of homelessness, overt institutional discrimination and low level of education, detainment and employment. The mental health burden of disease is much higher in the NT compared to national average. In the NT, mental health conditions contribute to 16.3 per cent of the burden of disease, compared to 7.4 per cent in Australia as a whole.

Young Territorians are over-represented within mental health services compared to other age groups, with young people aged between 15 to 24 years constituting 25 per cent of all community-based clients, despite being only 15 per cent of the population. So almost a quarter, which is 23.3 per cent, of Aboriginal and Torres Strait Islander Territorians experience high – very high – psychosocial distress, also twice the national average of 11.8 per cent. The NT experiences a rate of death by suicide of six times the national average. Upstream social determinants such as poverty, unemployment, drug and alcohol use, family violence, chronic disease, ongoing grief, loss due to high rates of mortality and imprisonment, are central to the disproportional high rates of suicide and psychosocial distress experienced by Aboriginal and Torres Strait Islander people in the NT. These issues heighten the need for accessible, culturally safe, high quality mental health services and for whole-of-government strategies to address social and economic disadvantage.

MS DAVIS: So I guess Vanessa's painted the picture of what we're dealing with in the Northern Territory in terms of mental health here and our mental health care. So I'm going to go on and talk a little bit about the provision of services here and I guess the biggest issue here is the scarcity of the services.

MS ABRAMSON: Yes.

MS DAVIS: So we have a scarcity of services across the healthcare spectrum, from low-to high-intensity, and it's a significant cause of low access rates amongst particularly rural and remote communities here. The widely dispersed and comparatively small rural and remote populations of the Northern Territory is supported by a mental health system that is skewed towards high intensity services which are often under-resourced and tasked with providing mental health care across vast and isolated regions. It's notable that the Barkly region alone is larger than the state of Victoria, yet its many remote communities are serviced primarily by a small number of NT Department of Health and non-government

mental health practitioners based in Tennant Creek, which is a long way from a lot of those communities.

The evidence that is available to us at the moment demonstrates that there are significant economic as well as social benefits for investing in prevention and early-intervention, and I think you've been hearing that today and we'd like to see a focus there, particularly focusing on young people with mental health.

However, in many remote communities across the NT, low-intensity prevention and early-intervention services are largely unavailable - and we know this from the work that we've done in gathering providers and others together, to talk about that - with child and adolescent services being particularly under-resourced across the Northern Territory.

We welcome the opportunity to make the recent submission to the Productivity Commission draft report, and we highlight in particular the draft report's recognition of a number of factors, including the need for access to culturally safe, person-centred care within a stepped-care model; the critical role for consumers and carers in guiding system improvements; a focus on prevention and early-intervention; and improved data collection, monitoring, and evaluation. We think that that's an important part of the model.

However, the Northern Territory Mental Health Coalition has outlined a number of key concerns for reform in this jurisdiction; a primary concern is that the draft recommendations may inadvertently exacerbate already difficult situations, such as those that exist here in the NT.

With respect, we feel that the Commission would be well-placed to give further consideration to the implications of the draft recommendations in complex environments, such as the provision of services in disadvantaged, rural, remote and very remote areas across the Northern Territory. We ask for further consideration of the critical role of community-based mental services in particular, to adequately address the service access, integration and co-ordination of care across stepped-care models, in order to realise improvements in mental health, particularly in our most vulnerable population groups, right across the NT as well.

The Coalition and our membership makes itself available to assist the Commission to gain a clear understanding of the role and value of that non-government community mental health sector within a mental health system. So I guess that's our key message to the Commission today.

MS ABRAMSON: Thank you.

PROF KING: Just start by following-up on that last part with the two directors. So thank you, Vanessa for the opening comments. So I guess our approach to thinking about services, not just in rural and remote areas, but in all areas of Australia, is to try and set up a structure, particularly for psychosocial supports.

So a starting point is that it's very ad hoc, it's ad hoc funding, pull the funding, fly-in, fly-out, you don't know if the funding is going to continue. So to try and stabilise that system and to create a funding system that could be regionally focused, to make sure that what is needed - what is needed in central Melbourne is completely different from what is needed in (indistinct) region.

And that was really behind our regional funding approach. We had alternative models presented, which we asked for information on. But yes, looking through your submission on the first draft submission I thought, "Well, is that approach wrong or have we been at too high a level, so that the providers on the ground can't see what we're trying to do?"

Because your view is we've sort of missed it, and so I'd really like to get into more detail.

MS DAVIS: Did you want to extend on that, or?

MS HARRIS: Yes. Look, I think we're not saying you've missed it; we just actually haven't had a chance to really workshop and think about it a bit better. Because I think one of the things we have in the NT is, we have only two funding providers here for us: the Northern Territory Government and the NTPHN, NT Primary Health Network. They're the only two here.

Now, I'm not going to make comment on whether they're working efficiently or effectively, or even co-designing or whatever they do, but what we're saying is, if you put another layer into that system, it then makes what we've got at the moment extremely more complicated than what we've got. So it's probably the devil you know, rather than the devil you don't at the moment.

So if we could have more, you know, time to look at what that third model looks like, given we've got two models already in the NT? They're the only funding bodies here in the NT, only funding providers.

PROF KING: I guess our build model was to say, well, part of the problem - in other words, well actually you can say it is the problem, easily. We have received other evidence to say that there is a lack of co-ordination in the NT between the NT Government and the PHN, and one of the approaches that we were trying to do with a regional commissioning authority as one of the alternatives was to say, "Well, let's bring the mental health money from the PHN," which is about 60 per cent of our budget, "together with the Northern Territory Government mental health money, separate it off from government in through a regional commissioning authority, so that there would be one body to co-ordinate the services.

And the aim or objective there is partly to avoid the problems of co-ordination, which we see in the Northern Territory but we also see elsewhere in Australia. So any thoughts on that?

MS DAVIS: And I think there's been numerous needs assessments done across all, you know, parts of the healthcare model in the Northern Territory, and the number one has always been the lack of co-ordination and integration across services. So it is a big problem to solve, I guess, and I guess certainly something that bringing the money together so that you can address the needs.

But I guess what we're saying is, the needs are different, particularly rural and remote, and very remote in particular, and they're probably greater. And we're also dealing with all of the social determinants as well, so we have a system that needs to give consideration to the social determinants and where we're at in terms of really taking a holistic and more comprehensive approach to resolving our mental health concerns here.

MS HARRIS: And I think the PHN, in all its worldly way it works, is that they're very active in funding Aboriginal organisations to deliver mental health services. I absolutely don't have any issue with that as the peak body for community mental health, but I think we need to also keep thinking that people who are receiving services have a right of choice of service, okay?

If they don't choose to go to an Aboriginal medical service where there are social and emotional wellbeing programs funded through the Commonwealth government, funded through the PHN, funded through the NT Government, they go to another service which might be one of our mainstream services, and feel that they get a better service there. They still have a right of choice of service.

PROF KING: So I completely understand; that argument has definitely been put up to us, but particularly in the higher population density parts of Australia. So you mentioned Tennant Creek before, so if we take say, Tennant Creek; is the population there - and if we brought them out into the Barkly Region, is it sufficient to actually sustain multiple services so that you can have that choice? Or is it the case that simple practicalities mean that there will be only one service that's viable?

And then it can be a choice: well, is that say, an ACCHO delivered service, or is that a service delivered by a non-indigenous NGO? Put those aside for one moment, exactly who the service provider is, but just coming back to actually, is that choice realistic outside Darwin and possibly Alice Springs? In the NT, is that choice realistic?

MS HARRIS: Well, I'll give you an example, Tennant Creek doesn't have a bulkbilling GP.

PROF KING: Yes.

MS HARRIS: So, there is no choice in Tennant Creek at the moment.

PROF KING: Yes, that's what I mean.

MS HARRIS: It's either the hospital or the Aboriginal Medical Service.

PROF KING: Yes.

MS HARRIS: So, if you don't feel comfortable at the Aboriginal Medical Service and you're an Aboriginal person, you're accessing the hospital.

PROF KING: Yes, but what I'm getting at is - - -

MS HARRIS: Yes, I know what you're saying.

PROF KING: - - - that's just simply driven by population and the economics, but you can't – for a small population base, you can't allow that choice. I'm just putting forward a view.

MS HARRIS: Yes, but I think you also need to consider that the Aboriginal community control haven't been caught up in the NDIS. A lot of them haven't signed up here in the NT. There's only two that have signed up because they have PIR and PHAMS. So, their funding is from the Federal Government. It's pretty well set. It's pretty well – you know – so, I think some of that is that the PHN also support a lot of that work in that they lobby like the rest of us to get funding as well.

I think that money for mental health is tied through the grants that come in from the Federal Government to the community control. Now, my service is having to build through the NDIS, so we're all subject to the NDIS and their clients being participants of the NDIS.

MS DAVIS: I guess we've talked a lot about early intervention and prevention and making sure that there's investment there and I think there are a lot of community mental health providers and other providers out there that are doing that work. They're working with families. They're working with children or have the capacity, certainly have the capacity to do that, which will then have flow-on effects to the mental health system.

It will have social and economic benefit to the mental health system. So, ensuring that the community providers are adequately accessed to provide a range of options for people to access services is important and that it's a part of the system that also needs attention I guess.

PROF KING: I wanted to go to the workforce.

MS ABRAMSON: I was going to ask about the workforce. One of the things that is really apparent in the Territory and you mentioned, Vanessa, really thin markets and so lack of people who can provide the services. We've been thinking a lot about this issue you would have seen in our report.

The answer in some areas is telehealth but that's not the answer to everything. So, I'm just interested in what we can do around the workforce?

MS HARRIS: We've just undertaken a project late last year, 2019. We got some really good support and funding from the NTPAG and we looked at workforce around the mental health peer support workforce and we engaged Wellways in Victoria. So, that has been very successful for us. It was a pilot just up here.

MS ABRAMSON: Yes.

MS HARRIS: There is no peer support network here. There is no linked experience network here. We've been working really hard and applying for quite a lot of money and just been knocked back every which way. We have started with Wellways and it came up and we had a steering committee. We had 55 applications for the – we contextualised the tender to a six and 22 started and 17 graduated from the six-day program. All identified with mental health lived experience.

MS ABRAMSON: Yes.

MS HARRIS: Wellways sent two trainers up, very experienced trainers, that worked through those six days with these participants, and then they went on in August just recently to do the facilitator training. Now, they're actually out there training in pairs. They run a men's program through one of the Aboriginal rehab services and they're just at the moment running another women's program, then they'll do a joint one.

So, we have actually given a bit of a career path to people who haven't worked for a long time because of their mental illness, but also now are facilitators. Because they haven't worked for a long time, we have employed them as casual employees for this part of the project to then facilitate and deliver the programs, My Recovery program. So, what we have been trying to do is grow our own peer support workforce. That's what we're trying to do as a peak.

MS ABRAMSON: I should know those because I have read the submission. Is one of them in the submission, that program that you just talked about, your pilot?

MS HARRIS: No, I can send you some reports on that.

MS ABRAMSON: That would be fabulous because it sounds like a really interesting – I don't remember in the submission. It sounds like a really interesting program.

MS HARRIS: Yes. We did a needs assessment first with some funding for the PHN around who is doing peer support, what does it look like. We looked around Australian through the Community Mental Health Sector, which is CMHA.

MS ABRAMSON: Yes.

MS HARRIS: Then we looked internally and then we started this project. So, we've just reported it to the PHN around that, so I would be happy to talk to you about that report and what it looks like.

MS ABRAMSON: We'd be really interested, thank you. You've got the email for our staff?

MS HARRIS: For Erin, yes, we have.

MS ABRAMSON: Absolutely, thank you.

MS HARRIS: We've also been invited to participate as the NT in the Mental Health Commission developing – I think it is guidelines around the peer support for national.

MS ABRAMSON: The Mental Health Commission, yes.

MS HARRIS: So, they've had our voice in that as well which has been really interesting for us.

MS DAVIS: Yes. I mean it's an approach that builds the capacity and the strength and builds on the strength of community to be able to address the issues that exist within communities.

PROF KING: Thank you, Vanessa. Thank you, Judy.

MS HARRIS: Thank you.

MS ABRAMSON: Thank you. I will remember now about the Mental Health Commission or lack thereof in the Northern Territory, the lack thereof of this experienced workforce and the lack thereof of consumer choice.

MS DAVIS: Thank you.

PROF KING: Next the Mental Health Association, is it? Merrilee, if you could just for the transcript state your name and your organisation and any opening comments you'd like to make.

MS COX: Thank you. My name is Merrilee Cox and I'm the chief executive office of the Mental Health Association of Central Australia. Thank you for the opportunity to present today, to talk today. As you will be aware, I did submit a written submission.

MS ABRAMSON: Yes.

MS COX: I won't spend a lot of time going back over those things that were commented on, other than to say that I think it's a really welcome discussion being promoted through this process, and I thought the report was a fantastic exploration of the range of issues.

Some of the things that I wanted to talk to today is about that Australian and also the Northern Territory, we're not a level playing field.

MS ABRAMSON: Yes.

MS COX: I know you're well aware of that but I think it's a really significant issue.

MS ABRAMSON: We've seen that in some of other reports, Merrilee, that you would be across.

MS COX: That's right. I think that for our sector, the NGO sector - so we're a member of the coalition and actively involved and support that submission as well - I think one of the issues is that there has been a significant under investment in psychosocial support services here.

Because we are a Territory, unlike the States where probably in the past about two-thirds of the funds going into mental health came through the State and a third came through the Commonwealth through the new initiatives, we're around the other way. So, we were really reliant on the Commonwealth programs, like PHAMS and PIR, for the expansion of the sector, and there hasn't been any significant increase in the investment by the NT Government in the psychosocial support sector for a very, very long time.

I think the other issue to speak to, the one which comes up about the lack of an NT Mental Health Commission, or the also only very short lived period with which we had a Chief Psychiatrist, is that we haven't had that for the leadership and conceptualisation of what the role and function of the NGO sector is.

What that means also, and I think this is an issue beyond just health services, is that our service is not well designed and it doesn't match the needs. As an example, there's no Aboriginal Mental Health Policy in the Northern Territory, despite the fact, as Vanessa and Judy spoke to, it's a significant proportion of our population. We work in a cross-cultural context but we have no policy, broad policy framework or practice framework or investment in thinking about what is the significance of working in this particular cross-cultural context and what are the expectations and the appropriate building blocks of the service system in this context.

Likewise, we have no dual diagnosis capacity at all in the Northern Territory. We have significant issues of alcohol and other drug use as a very big contributor to both suicidality and to mental health difficulties, but no dual diagnosis framework system, not one scrap of funding going into that dual diagnosis area.

Likewise, we have some of the highest level of cognitive disability in the country and there is no brain disorder or ABI services at all in the Northern Territory. We don't have a strong match between the profile and needs of the population and the services that are available, and though this is not mental health, it (indistinct) on mental health.

There is no Auslan interpreter outside of Darwin, yet we have the highest incidence of hearing impairment in the whole of the country. What we see is that we've got a really big

mismatch between the profile of the people and the kinds of services that are available, and so the design work hasn't been done around our system.

I think that was one of the exciting elements of your report and I think you talked about that need to go back and think about the redesign and then a commissioning process that allows that redesign to occur. So, that was one of the things that I found really exciting about reading your report is going back and thinking about that.

I guess one of the other things about working in this constituency is also a thought about how funding is arrived at. We've currently got a piece of funding that's population-based funding. It's the national psychosocial measure which is supposed to equip our organisations responding to new and emerging mental health difficulties in the context of NDIS. Because that's a population-based piece of funding, channelled by the Department of Health through the PHN, that's \$16,000 a year.

MS ABRAMSON: Your need is like this and your funding is like this.

MS COX: That's right. So, you have \$16,000 and then alongside that \$16,000 goes the requirement to do two different kinds of monthly reporting, two different kinds of quarterly reporting, participation in meetings and forums and goodness knows what, which really probably pretty much eats up your \$16,000 a year. We've sort of also got into that position where we've got - if it is population based, it's problematic. We've actually got to start to think about how we arrive at an appropriate level of funding that is actually responsive to the need because it's a bit of a joke, \$16,000.

MS ABRAMSON: Do you have some ideas on that?

MS COX: Well, my thoughts are about us needing to have more of that discussion around the loading and the framework and I know that that was one of the things under the current National Mental Health and Suicide Prevention Plan was to go back and have a look at how those funding agreements were reached and the way that loading should work. I think it's been very publicly acknowledged at the Federal level that having a high indigenous population lends itself to the need to think about it a bit differently than you might in a different setting.

MS ABRAMSON: Yes.

MS COX: In many ways, I think that they were some of the key things that I wanted to talk about, but I think you also raised the issue of workforce.

MS ABRAMSON: Yes.

MS COX: I'm sure you've heard this before, but we have to build – workforce is one of the key reasons why nothing much has changed for a long time in the shape of our services because every service is limited by the need for a skilled, appropriate workforce. Just this week, I was speaking to the Royal Flying Doctor Service which is responsible for doing

some of the primary mental health care in remoter settings, where they fly in and out on a six-week basis.

MS ABRAMSON: Yes.

MS COX: At the moment, because they are down three staff, they can't travel. So, what can happen, services just come to a dead stop in the Northern Territory in a way it doesn't happen in other settings.

MS ABRAMSON: Yes.

MS COX: It's the tyranny of distance and the issues of safety and so on which can really prevent those things happening. I think we have to be investing in the community. We need to be building capacity at a local community level.

MS ABRAMSON: What does that look like? I mean we talked about the peer support and the Productivity Commission is absolutely there, and we've got some recommendations.

PROF KING: Yes.

MS ABRAMSON: So, interested in some of that research. What does it look like for you?

MS COX: Well, there used to be in the Northern Territory a commitment to the development of an Aboriginal mental health workforce, so that within local health services or within the local community mental health service, there was an Aboriginal mental health worker. They were people drawn from the local community who were assisted to develop the knowledge and understanding of what a framework of mental health looks like and to work in that sort of bridge-building way to support the engagement of community into those services.

There has been a really successful model implemented at Miwatj which is in East Arnhem Land where they have worked really strongly to do that using the Partners in Recovery funding as the vehicle for that over many years.

MS ABRAMSON: Yes.

MS COX: I think we need to look at those models where that has really worked and try to spread that out into other areas because unless we do – if we rely on a workforce that is all those young people that coming up from the southern and eastern States who are interested in an experience and then leave again after a couple of years, we get churn and we never get innovation and we never get that sort of maturation of service delivery. When I first moved to the Northern Territory, I was so shocked. I felt like I was about 25 years back in terms of the delivery of services, and also the engagement across clinical and non-clinical.

I think Tanya spoke a little bit to that where sometimes though the delineations themselves prove problematic. I think we have to invest in workforce and we have to build capability at a local level so that we can then start to build on top of that.

MS ABRAMSON: One of our biggest challenges, I guess, and we spoke a bit about this before, is when we looked at psychosocial, we couldn't see a system. But whatever we build, we have to build it in a way that it's responsive to local needs and that's the hard thing.

MS COX: Yes.

MS ABRAMSON: Because you're talking about NDIS, well that big program that's rolled out across Australia and we're thinking about, as Steven said with the commissioning, we wanted to match local needs, local planning needs with actually the need for particular services. So, it's kind of where we've landed there.

MS COX: Yes, and I understand that.

MS ABRAMSON: Sorry, Merrilee, one of my staff was just asking, the \$16,000 that you've got, how many people was that supposed to cover?

MS COX: It's for new and emerging mental health needs in the community. So, it doesn't specifically say but it does ask us to report on it.

MS ABRAMSON: Yes.

MS COX: Because there's no capacity really, it's not even a full day of an experienced worker's role, we're using it for the purpose of a referral.

MS ABRAMSON: Yes.

MS COX: We get between two and three referrals a week. So, if we do an adequate assessment of those two or three people, then we channel them back through the stepped care model because people in the community don't actually understand mental health care at all. That's how we're using it. We've sort of set up like a centralised sort of intake referral into the organisation because that's the only meaningful way that we can think of to do something useful with it.

MS ABRAMSON: Yes.

MS COX: I think as there is more awareness around mental health and more acceptance in the community or the de-stigmatisation of mental health, more and more people are coming to services like ours and asking us for support. When our services were established, we were mainly working with people with severe and enduring mental illness.

MS ABRAMSON: Yes.

MS COX: The only real investment in that earlier intervention and primary mental health space has really been the ATAPS initiative and it's not the appropriate response for a lot of people.

MS ABRAMSON: Yes.

MS COX: It works for some people but it's not the appropriate response and I definitely don't think it's the appropriate response for many of the people in our communities because of the issues that were raised before about all of those systemic issues that people experience.

In Alice Springs, our homelessness rate is 18 times that of the national homelessness rate and our rentals. So, to rent a property is somewhat similar to renting in Sydney. It's different to Darwin in that there's really different profiles. It depends where you are in the Northern Territory. In Darwin there's a very depressed property market which is sad if you own a property, but it has led to a more affordable rental, private rental. In Alice Springs, a one-bedroom flat sort of starts at about \$380 a week, so it's absolutely beyond that are on any kind of welfare income, so we have massive homelessness.

Sending someone off to attend psychology sessions when you're homeless and have no running water and nowhere to wash your clothes, it feels tokenistic at best. We need to be sort of thinking about that. You could talk about it as early intervention or talk about it as that primary mental health care space. Essentially, in that space a lot of the work that needs to be done is helping people to negotiate and deal with the social conditions in which they're living.

MS ABRAMSON: Yes, it's interesting because as you will have noted in our report, we had a very strong emphasis on housing.

MS COX: Yes.

MS ABRAMSON: It was very clear for us from day one that this was a really – somebody cannot function at the level they might be able to if they've got insecure housing issues.

MS COX: That's right, yes.

PROF KING: Just one point. You were here for the earlier discussion with the Northern Territory Mental Health Coalition on choice. Any thoughts on that discussion, the issue of choice and consumer choice which in a sense often lies often lies at the heart of the Productivity Commission work, but dealing with that in areas which have low population.

MS COX: I really don't feel very equipped to respond to that. I think it's very difficult but I think it's also very telling that it is a great deal of stigma about serious mental illness and in the Aboriginal community as well. I think there is also extremely low mental health literacy in that population and I think that sometimes and quite often where people are

welcome is in a mainstream service in the sense of the psychosocial support people are accommodated well in that setting, perhaps because of that greater level of mental health literacy.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you. That's been terrific.

MS COX: Thank you.

MS ABRAMSON: Thank you.

PROF KING: Let's now take a break for lunch. If we can recommence at 2 o'clock.

ADJOURNED

[1.02 pm]

RESUMED

[2.00 pm]

MS RYAN: Hello, Trinity speaking.

PROF KING: Hello Trinity, it's Stephen King and Julie Abramson from the Productivity Commission.

MS RYAN: Hi.

PROF KING: Hi. Can you just give us a minute? I've just got to go through the formalities to recommence the hearing and then pass over to you. So let me just recommence the hearing after lunch, and Trinity, if you would be able to state your name, just for the transcript, and any introductory points that you would like to make.

MS RYAN: Okay. Hi, my name is Trinity Ryan. I am speaking as an individual and everything I say is from my own perspective. Thank you for allowing me the opportunity to speak. I've been a consumer of the mental health system for about 20 years. My diagnosis is schizoaffective disorder, a severe mental illness, in my case involving symptoms such as psychosis and severe depression. I manage to work part time and live alone, yet do still require support. I will need medications for my entire life, and a psychiatrist who will work with me to manage those. I also require case management and counselling support. This in itself is time-consuming and means I am limited in how much I can work.

This is why I strongly believe that the disability support system needs to be made more accessible to those with a persistent mental illness who are working part time. I have not worked more than 15 hours in a week for the past two years due to my mental health

condition, yet was deemed ineligible despite doctors' evidence. In fact, I never even met with an assessor or discovered why my claim had been rejected. Doctors' evidence with up-to-date assessment tools should be used to prove the DSP application. When instead relying on outdated testing models and unskilled workers, too many people are going without the assistance they require. The difference in payments between the Newstart and the Disability Support Pension is extreme, particularly difficult for those already on a tight budget. This can lead to people feeling they are being punished for working or for looking for work, thereby removing any incentive. For example, someone with a severe diagnosis and prognosis who is able to work part time despite it being extremely difficult and often detrimental to their wellbeing may not receive the help they need. To enable people to work part time while not rejecting claims on this basis would allow those with a severe mental illness to feel supported while contributing to the workforce, thereby encouraging those on the DSP to work when and if they are able.

The financial burden of medication for a consumer, especially those without a concession card, should not be underestimated. While concession cards greatly bring down the cost of medication, there are those who are living on lower incomes yet are past the threshold for the low income healthcare card. Affordability can become a problem when forced to choose between buying expensive medications and food. If the low income healthcare card or something similar was made applicable to a wider range of people, including those forced to remain on multiple expensive prescriptions, the consumer would be more likely to be able to afford their medication. Although I am able to manage my illness myself the majority of the time, needing ongoing prescriptions means that I also need to see a psychiatrist with whom I can build a therapeutic rapport. These medications are highly complex, with seemingly similar drugs having very different side effects and benefits. With such complex medications along with even more complicated symptoms, ongoing visits are necessary to ensure my treatment is kept up-to-date.

When altering medications, it can be necessary to see an experienced doctor multiple times in a week in order to make adjustments. This can only be done if the client has affordable access to a doctor they can trust. Any debt that a consumer has to pay through the MBS piles up when the frequency of sessions is so high. Finding a psychiatrist that bills under the MBS is not possible either. Currently, affordable psychiatric care is unavailable until crisis point is already reached. This exacerbates the person's condition and greatly extends the length of time required for recovery. This in turn places further pressure on an already overwhelmed health system, particularly at this emergency level where services are needed most. While in some cases the care of a psychologist is sufficient, in other cases, the expertise and training of a psychiatrist is required. In these cases, it is far more efficient to provide preventative care than to wait until that crisis point is reached. As psychiatrists outside of the public health system are highly expensive, with, at a proper cost, well into the hundreds threshold sessions, maintaining a useful therapeutic relationship becomes impossible for many. In short, we need better ways of funding psychiatry for those who need it most.

The largest barrier to my personal productivity has been stigma and bullying within the workplace. I want to clarify this was in a previous job. In my current position, I am treated

with dignity and respect. I was bullied for a period of about six months before finally leaving the former job. During that time, the store manager was verbally abusive, shouting at me both on the shop floor and in the office. I was questioned consistently about my medications and told they are ‘just like Panadol, up the dose if you need to’. This constant questioning and abuse exacerbated my condition, causing my self-esteem to become dangerously low. My physical health suffered further, as I was not permitted to take rostered breaks at work and was forced to skip meals because of it. With a BMI of about 15 and weighing 34 kilograms, my body had begun to consume itself. This led to such heavy bleeding and intense pain that I believed I was having a miscarriage.

PROF KING: Take your time, Trinity, and thank you, because we have read your submission where you outline the details.

MS RYAN: Sure. My performance was then managed for taking a day off to see a doctor. Shortly after, I was suicidal. Once crisis services intervened, they were able to assist with my mental health but not my situation at work, as they were not equipped with any WorkSafe information. Although I have regained my confidence and the weight over the two years since I left, I am still unable to physically have a child due to the damage done. I don’t know if I will ever be able to. When I did take the case to WorkSafe, I was informed by the business’ insurance company that due to my pre-existing conditions, the manager could treat me however they like.

This is unacceptable. In terms of workplace health and safety, with particular regards to stigma and bullying, we do have pre-existing laws. These laws, however, need to be strengthened and reinforced by holding those with health compliance laws. There needs to be WorkSafe representation for employees in matters of stigma and bullying. While I agree that no-liability psychiatric sessions are a start for this reform, the employee remains under-represented in these matters. In addition to this, due to the psychological impact of bullying, employees may find that they are incapable of presenting their case to WorkSafe at that time. They require support through this already traumatic process in order to achieve the outcome they deserve and return to work as fast as possible. A longer time frame in which to make a complaint would also assist workers to focus on their recovery first, making it less stressful. In cases where the employers fail to meet their responsibilities, I would suggest a compulsory education program based around stigma reduction in a workplace. In this way, the overall standard of workplace health and safety expectations can be lifted, thereby reducing ignorance in the workplace and providing a more inclusive society for all of us. Thank you.

PROF KING: Thank you, Trinity.

MS ABRAMSON: Thank you very much, because I’m sure it’s very difficult to give this type of evidence. What I wanted to know, Trinity, was in your current employment, focusing on the positive, what is it about that workplace that makes it an inclusive workplace for you?

MS RYAN: From a management level down, they have instated programs such as mental health training for all managers. They've really taken initiative to go above and beyond the normal expectations of what a large retailer would. So things like promoting mental health in the workplace, mental health days and things like that, mental health awareness. Even just little things like having fruit available in the tea room constantly, making sure that each other feels valid as a team, not as a – picking on any one individual.

MS ABRAMSON: Trinity, are there any – one of the things that we were looking at is the type of leave that's available to employees, and so were there any particular things about where you work that are very helpful for you? Like, you know, in terms of needing a medical certificate for a day off or a particular attitude to those things?

MS RYAN: I would say that the flexibility of where I work is very helpful. I don't know if that's because of where I work in particular or if that can be applied on a wider scale. But they are very flexible with shifts, so – with moving shifts around. You can work on different days, for example.

MS ABRAMSON: Yes, see, one of the things we've observed is - it depends, obviously, on the nature of the mental illness – but one of the difficulties is the episodic nature of mental illness, at least from an employer perspective. That's why I was quite interested. The flexibility actually does matter quite a lot. Not all jobs, obviously, can be designed like that. But clearly if you've got flexibility, you can use it in a – and there's a good culture that sits behind it, you can use that to get, sort of, the days that you need to see your psychiatrist or seek treatment. So that's quite interesting to us.

MS RYAN: Yes, absolutely. Yes, absolutely, all the things you mentioned. Getting treatment - getting well in general – it does take time, so being able to take that time when you need it and being able to come back to work and not have to answer questions about it is another really big one.

MS ABRAMSON: So you've got - - -

MS RYAN: So to just be able to come back to work to be under the assumption that because you're there, you are well enough to work and they're happy to have you back, rather than sort of undermining you coming back is quite excellent.

MS ABRAMSON: No, it makes perfect sense, Trinity, because what you've really outlined is a number of conditions that are needed to be able to be in the workplace. And so that seems about leadership from the top of the organisation, which sounds like you have there, and also education for the staff, but then that has to be married with flexibility about how you do your job.

So I know I was focusing on the positive and you've brought our attention to the difficulties you've had in the past, but that was because we're looking to make recommendations that can help people in this situation, so that's why I was exploring that particular piece of your evidence.

MS RYAN: Yes, absolutely.

PROF KING: Without naming the former employer, as I understand you were with a retailer that is a large group; was the previous retailer that you were working with, were they also part of a large group, or was it a single, small store?

MS RYAN: They were kind of a large group as well, but it was a separate large group, different entity.

PROF KING: Yes, understand. Because obviously we're trying to work on carrots and sticks, incentives and where they can work for employers to create mentally healthy workplaces, and making sure things such as you mentioned, the mental health training for all the managers, occurs. In the previous organisation, that just didn't occur, from your knowledge, at least?

MS RYAN: No, there was nothing like that. I believe some managers were trained with a physical first-aid certificate, but there was no mental health training, very little knowledge within the workplace about it. And yes, a lot of stigma because of that.

PROF KING: Do you have any thoughts about, was it a cultural problem in the organisation, or was it just the one manager at the store level, or was it a bit of both?

MS RYAN: I believe it was cultural.

PROF KING: Okay.

MS RYAN: I did try and go higher-up, and yes, faced similar difficulties, I believe that ran through.

PROF KING: Okay. Just briefly, on a slightly different issue: you mentioned right at the beginning, you gave us your diagnosis; one of the things that we've had very mixed views back on from consumers is the issue of diagnosis. So I guess I'll put them into three groups: we've had some consumers who have said actually they would prefer not to have a diagnosis; they think once they get a diagnosis, they get pigeonholed, that it actually makes their recovery more difficult.

At the other end of the spectrum, we've had some consumers who have said, "Oh, and I got the diagnosis, thank goodness, because now I know what's wrong with me." And in between we've had consumers who have talked about the problems they've had with diagnosis, where they've had multiple diagnoses, it's been changed over time, and finally, they've got what appears to be a correct diagnosis but it's been a very traumatic period in their treatment.

So what was your experience there, and do you think a diagnosis is helpful, and how did you find that process?

MS RYAN: For me, having a diagnosis has always been helpful. It has changed over time what that diagnosis has been, whether it's schizophrenic with a mood component itself, and a mood component with depression. I think over time, the DSM actually changed that into schizoaffective.

PROF KING: Yes.

MS RYAN: But yes, having read the DSM-IV article on that, I'm quite happy with my diagnosis; I think it's correct. And I find it helpful in helping me know what to do about it; so when I do have those symptoms, I can put it down to that. Sometimes, I can find my way through it. And yes, I find the diagnosis helpful for me; I think for a lot of people they don't, but for me personally, it's helpful.

PROF KING: Just one final one from me. You mentioned low availability of psychiatrists and psychologists.

MS RYAN: Yes.

PROF KING: Issues of co-payment and bulk billing. In our draft recommendations, we talked about online, and for example, mind spots is an example for moderated online therapy, particularly for mild mental illness and mild anxiety, mild depression.

MS RYAN: Things requiring high-end medications, but it would concern me, the face-to-face interaction I feel is important; there's kind of no real way yet of replacing that, you can go with the internet and stuff. The other thing I would say is just would they be able to write prescriptions, then how would that work?

PROF KING: Usually, that would have to go back through a GP or something.

MS RYAN: Exactly, yes. So it becomes an extra step in a process for anyone seeing that psychiatrist online. I'd worry that more people may fall through the cracks in between that kind of seeing the psychiatrist, picking-up the medication from the chemist; it is an extra step and I know a lot of people do have difficulty staying on their medication at times.

PROF KING: Yes, I guess the thing we're grappling with is exactly that issue, that it can create extra steps, versus the exact problem that you mentioned, where we've met consumers who simply can't afford - - -

MS RYAN: Yes, I would say - - -

PROF KING: We're in Darwin at the moment and there's not too many psychologists or psychiatrists in the Top End.

MS RYAN: Yes, absolutely. So I'd say it's definitely worth looking at as an option, bringing in the Internet psychiatry, because then you can apply it to people that either don't

require the medication, or just simply don't have access at all, to other psychiatry and need that extra step, rather than driving a thousand miles or whatever. But in case that makes it easier or more possible, then it's obviously a good thing. But I think there is still value to the face-to-face connection.

PROF KING: Your view would be it's second best, but it's better than nothing.

MS RYAN: Yes, exactly.

MS ABRAMSON: Trinity, I wanted to ask you something that's not in your submission, but feel free not to answer it if you don't want to. One of the other issues that's been brought to our attention really is by the relatives and support people for the consumers, who've said that because of privacy laws, they've not been able to be told about a relative's condition; and we're thinking about this at the acute end, so a presentation to Emergency, and then the person being sent home to the family without them being able to understand what they can do to assist the person.

As Stephen said with another issue, we've had kind of mixed views; one of the views put to us is that properly explained, most consumers would give that consent. Not all, but most people would. And I wondered if you'd had experience of that, or you had a view about it? If you don't, that's absolutely fine.

MS RYAN: I was very down at first, first coping with my illness; it was before I was actually even diagnosed properly. But I did receive a lot of advice on confidentiality, privacy, I was told I didn't have to tell anyone; it was kind of very hidden from my family. And in retrospect, I think it would've helped a lot to have told them a lot more. I don't think - well, basically I think there would be a way, ways, around the privacy and confidentiality so not necessarily breaking anything private but something to be able to give the family and carers the information they need to look after someone. The access to the basics of the information that we have on that illness - - -

MS ABRAMSON: One of the things we've been thinking about is it's got like a legal name but it's an advanced care directive, and that would mean - it's used in other parts of the health system - that when you're well, and I understood the issue about being a young person, but when you're well you can say well this is actually the type of care I want and these are the people that I want informed about my situation. So that's one of the practical things we've been thinking about.

MS RYAN: I believe there are already advance care statements that exist.

MS ABRAMSON: Yes.

MS RYAN: I think the trouble with those is they're not used enough. Even I don't have one, and should, but there's often so many things that you think you might need in the time or you don't know but you can't predict what you're going to need or what you're going to want even when you're in that moment even when you're looking at it from a healthy

perspective.

MS ABRAMSON: No, I understand. Look, you've been very courageous in talking to us so thank you for that because it helps us make a difference for other people, so thank you so much.

MS RYAN: It's my pleasure.

PROF KING: Thank you very much, Trinity.

MS RYAN: Thank you, bye.

PROF KING: Bye. Next we have the Aboriginal Medical Services Alliance Northern Territory.

MS ABRAMSON: Who no doubt can give us some information about advanced care directives.

PROF KING: And whether clinicians pay any attention to them, which is one of the issues.

MS ABRAMSON: That's right.

PROF KING: If you could just introduce yourself and state your organisation and any introductory comments you would like to make for the transcript?

MR PATERSON: Sure. Thank you. So, chairman of the - - -

PROF KING: Stephen.

MS ABRAMSON: Stephen and Julie.

MR PATERSON: Are you sure, okay, cool, that's the way I like it, not all these formal titles and greetings. But let me say, let me introduce myself, John Paterson. I'm the chief executive of the Aboriginal Medical Services Alliance Northern Territory. I am also a member of the Aboriginal Peak Organisations of the Northern Territory, which is an alliance between the Northern Land Council, the Central Land Council, the Aboriginal Housing Northern Territory, and I'm also a territory representative from the Coalition of Peaks on the Joint Council of Closing the Gap. But I will be speaking today in my capacity as the AMSANT chief executive but I will make references - I would like to share some of the work that's going on nationally with the Close the Gap stuff.

PROF KING: Yes.

MS DYALL: Good afternoon, my name is Danielle Dyll, I am the social emotional wellbeing and trauma informed care manager for the Aboriginal Medical Services Alliance

Northern Territory.

MS BURGOYNE: And hi, I'm Daisy Burgoyne, I am service integration lead for mental health and suicide prevention, also work with AMSANT.

MS ABRAMSON: Thank you.

MR PATERSON: All right, well I will make a statement, read out the statement and then between myself, Danielle and Daisy we'll take and field any questions you might have of us. I would like to start by acknowledging the Larrakia people as the traditional owners of Darwin region where we meet here today and pay our respects to Larrakia elders past, present and future. I thank the Productivity Commission for the opportunity to attend and present at this hearing today.

The Aboriginal Medical Services of the Northern Territory, known as AMSANT, is the peak body of the Aboriginal community controlled primary health care sector in the Northern Territory. We have 25 members, member services, providing care to communities across the Northern Territory from Darwin to the most remote regions. Our services' comprehensive approach incorporates clinic care with social and emotional wellbeing, mental health, and alcohol and other drug services as well as family support and early childhood services delivered by multidisciplinary teams in a holistic service model.

AMSANT was very pleased to see the focus in the commission's report on the key social determinants including housing and homelessness. Contact with the justice system, income support, social participation and the impacts of racism and discrimination. Aboriginal communities here in the Northern Territory know all too well that socioeconomic context exerts a powerful influence on the distribution of health commissions and mental disorders through differential exposure, vulnerability, and access.

Public policies that focus on narrow measures of disease burden or economic productivity continue to position the mental health crisis within a biomedical, individualistic model. This inevitably leads to policy arrangements systems and services that drive unequal distribution of opportunity and creates ineffective and potential harmful outcomes. Here in the Northern Territory we see this reflected in the alarming numbers of Aboriginal people with poor mental health who find themselves on a trajectory to hospital, homelessness, and prison.

With our recent submission and our appearance here before the commission today we hope to demonstrate that there is another way forward, one which acknowledges the past and builds on the strengths that have kept Aboriginal people well for thousands of years. The Indigenous model of social and emotional wellbeing, otherwise known or referred to as SEWB, is holistic and integrated bringing together social and cultural supports with clinical care in a primary health care setting to support individuals, families, and communities, in all aspects of life that strengthen wellbeing.

The National Mental Health Commission's 2014 review of mental health programs and

services recommended that integrated mental health and social and emotional wellbeing teams should be established in all Aboriginal community controlled health services. Despite this our services are still often forced to contest for service delivery contracts for mental health services. Often these contracts are awarded to large mainstream NGOs who may have more capacity to present impressive grant applications but are often culturally inappropriate and lack relationships with the local communities.

Because of this our first and central recommendation to the commission is that Aboriginal community controlled health services should be recognised as the preferred providers of all mental health and social and emotional wellbeing services for Aboriginal and Torres Strait Islander people with adequate funding committed to fully realise the National Mental Health Commission's 2014 recommendation.

It is our view that the complete realisation of this recommendation will require at least the following; firstly, continuity of care for Aboriginal patients should be centred around Aboriginal community controlled health services as the link between government health services and hospitals, NGOs, community centres, outreach programs, and the local Aboriginal population.

We note in particular that this must include access to specialist child and adolescent mental health services which are effectively non-existent in many remote communities in the Northern Territory. This is deeply concerning given the high levels of trauma, mental health issues, and suicide that we see among our young people.

Secondly, we must improve connectivity between the different layers of the service system by creating sufficient pathways for access to community-led healing programs that are strength based and address the social determinants.

This requires dedicated funding to provide wraparound care through effective community-led mental health and wellbeing programs that facilitate regional service integration, case management and care coordination.

The early success of the Katherine Individual Support Program in reducing emergency department presentations and increasing access to primary health care demonstrates that this approach works and we refer you to page 6 of our submission for more information on that particular example.

And finally, we must build a stable and sustainable workforce made up of multidisciplinary, culturally and trauma informed teams with expertise across the various aspects of wellbeing for Aboriginal communities. Building this workforce locally through investment in traineeships, scholarships and mentoring schemes is essential.

Importantly, we would like to take the opportunity today to comment on the commission's recommendations to renovate or rebuild the approach to mental health funding in Australia. While there are some advantages to funds pooling, as suggested under the remodelling - the rebuild model, AMSANT is concerned that the proposed approach could see funding

that is currently directed from the Commonwealth to the Aboriginal Community Controlled Health Sector, filtered through the newly proposed regional commissioning agencies and put out for public tender.

Past experience has shown that when Aboriginal, alcohol and other drugs and social and emotional wellbeing funding became subject to increased competitive tendering under the Indigenous Advancement Strategy, there was a shift in service funding towards mainstream NGOs, in many cases leading to increased fragmentation and duplication of services. More than this, however; such a shift undermines community self-determination and the opportunity for local employment and capacity building.

Because of this, instead of blanket implementation of the rebuild model, we would like to see emotional - the social and emotional wellbeing funding currently held by the National Indigenous Australians Agency returned to the Indigenous Health Division in the Commonwealth Department of Health.

Then all Aboriginal-specific mental health, social and emotional wellbeing and suicide prevention funding should be funded direct from the Commonwealth Indigenous Health Division to the Aboriginal Community Controlled Health Sector.

Additionally, we would like to note our support for the commission's recommendation that indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal people. In order to facilitate this recommendation, we'd also like to see a policy imperative that all indigenous suicide prevention funding that is currently going to mainstream organisations be redirected to Aboriginal organisations within the next five years or whenever their current funding agreements expire.

The commission's report suggests that governments need to make a choice as to how to tackle mental ill health in the long-term. Our suggestion goes further than that, to healing intergenerational trauma and dismantling systems that continue to oppress Aboriginal people. The long-term aim is that our health status matches the wider community. This can only be achieved through self-determination.

The commission's report states the limited control that Aboriginal and Torres Strait Islander have and feel that they have over the circumstances in which they live is seen by them as limiting both their social and emotional wellbeing and their ability to do anything about it.

In 2017 at the National Constitutional Convention, after months of consultation around the national, Aboriginal and Torres Strait Islander leaders came together and produced the Uluru Statement from the Heart, setting out an invitation to non-indigenous Australians to join with them in a process of truth-telling and political recognition of our First Nations people.

Our final call to the commission today is for you to acknowledge the importance of political recognition and truth-telling in improving the mental health and wellbeing of Aboriginal

people, with a recommendation in your final report that calls on the government to honour the Uluru Statement from the Heart. We'd be happy to take any questions. Thank you.

PROF KING: Thank you very much, doctor. Can I start by - I really want to explore the area of the Community Controlled Health organisations, the funding, so - are you familiar with the recent Victorian Royal Commission recommendation, by the way?

MR PATERSON: (Indistinct)

PROF KING: I can summarise it very briefly. So what they've recommended is that all Victorian mental health funding - and I'm going to get this slightly wrong because I don't have it on me, but all Victorian mental health funding for Aboriginal Australians in Victoria be directed through ACCHOs, where ACCHOs exist, and where they don't exist, there is a transition body. I know I've probably got the name wrong - - -

MS ABRAMSON: Yes, I'm just looking for the recommendation.

PROF KING: Yes. That will work with the community so that an ACCHO can be created.

MR PATERSON: Yes. Yes, yes.

PROF KING: So that the funding can be - so that's - so what I'd like to do is a sort of step up to that. So some people got back to us at draft when I asked the question, well, should funding go through ACCHOs? Their response was, well, ACCHOs don't exist everywhere, ACCHOs have different capabilities. It needs to be community controlled organisation that don't say ACCHOs. So we didn't. In our draft report, we - - -

MR PATERSON: Yes.

PROF KING: So was that right or - because now we're seeing the Victorian recommendation - yes, "Social and Emotional Wellbeing in Aboriginal Community Controlled Health Organisations". Yes. Now we've seen the Victorian recommendation which says Aboriginal Community Controlled Health Organisations and we say, well, did we go down the wrong path? Should we have been much more explicit and just said the exact same words as the Victorians?

MR PATERSON: Yes. We would totally agree with that, that reference. And the reason - and then that's the position of the AMSANT membership here in the Northern Territory. I can't speak for other jurisdictions, you know. Some will have a strong wish for it to go through the Aboriginal Community Controlled Health Sector.

In the Northern Territory, we have the commitment from the Commonwealth and territory governments that all Northern Territory remote clinics will transfer the responsibility of delivering comprehensive primary healthcare across to the Aboriginal Community Controlled Health Sector and I'd like to say, commissioner, where there's no existing health service, Aboriginal health service, then we will rebuild - we'll build one.

PROF KING: Yes.

MR PATERSON: Or where there's existing Northern Territory government-run clinics, then it's just a matter of, you know, establishing and getting an incorporated Aboriginal health board to then eventually take over the transfer and the transition of the responsibility of delivering the comprehensive primary healthcare and we've got a couple of regions in the Northern Territory where that currently is happening.

In the East Arnhem region, all clinics there now - they were previously run by the Northern Territory government. They have now transferred its responsibilities to the Miwatj Aboriginal Health Corporation there, so Miwatj is the sole governing responsible agency, service provider for delivering comprehensive primary healthcare in the East Arnhem.

And that's - look, I just want to refer and I understand we sent you through a couple of copies of the communiques from the Joint Council on Closing the Gap and you'll see there, there's four agreed priorities that's been agreed to by the Prime Minister, all the relevant first ministers in each state and territory, including our Chief Minister here in the Northern Territory, and I'd like to read that, because this is where we're getting that commitment now from a very, very high level of government, from the Prime Minister's office.

And it reads - number one priority - "Developing and strengthening structures to ensure the full involvement of Aboriginal and Torres Strait Islander peoples in shared decision making at the national, state and local and regional level and embedding their ownership, responsibility and expertise to close the gap.

Second priority, building the formal Aboriginal and Torres Strait Islander Community Controlled Services Sector to deliver Closing the Gap services and programs in agreed priority areas. And thirdly, ensuring all mainstream government agencies and institutions - that's governments and mainstream NGOs - undertake systematic and structural transformation to contribute to Closing the Gap.

And the fourth one was about the government funding us to the Coalition of Peaks \$1.5 million to build a data repository or a data portal, you know, at the push of a button which you'd be able to see what's happening in each community, you know, so that was basically that fourth - - -

MS ABRAMSON: And could I ask you about capacity building - - -

MR PATERSON: Sure.

MS ABRAMSON: - - - because we observe this everywhere, so for example we've been given evidence that some of the PA tend to do well, some not so well, and I know that when we've spoken to you previously that you do quite a lot of work around governance and supporting organisations, so I'm just interested in your organised views on that.

MR PATERSON: Sure. We're fortunate and lucky, I guess, here in the Northern Territory because AMSANT is a third shareholder of the Primary Health Network.

MS ABRAMSON: Yes.

MR PATERSON: So we've been there since the inception. You know, since those transitions of - I think prior to PHN I think they were Medicare locals or - - -

MS ABRAMSON: Yes, exactly.

MR PATERSON: Yes. They've had a few name changes and structural changes, but we've been an active member and now a third shareholder with the Northern Territory Department of Health and the mainstream GP services and their practice.

We've actually managed to influence the Northern Territory PHN in their commissioning framework that they have in there and they reflect the principles - the Aboriginal Peak Organisations has a set of principles when working between Aboriginal community controlled organisations and mainstream NGOs that there is a transition or a commitment to build capacity if there's no existing Aboriginal Community Controlled Organisation to deliver those services in particular areas, that the mainstream NGO will assist and support building or establishing an Aboriginal Community Controlled service provider, so eventually over the five years or whatever the term that they agree to in their negotiations, that the mainstream NGO will remove - withdraw from delivering the service.

They may still - there may still be a need there, but you know, because of the specialist care that may be required that the Aboriginal Community Controlled service provider may not have currently, but until such time as we build that capacity, there will be a need of those mainstream NGOs and other service providers to have some sort of involvement, but the leadership, the government structure, the goal setting, you know, the strategic planning, should be led by the Aboriginal leadership in the community or in the region or in the Northern Territory. You know, the Aboriginal peak organisations leading, you know, to close the gap and reform stuff at the national level.

PROF KING: Can I ask on exactly that, on that transition issue and that capacity building, one of the recommendations that has never seen the light of day from our human services report a few years ago was that all contracts to provide human services into indigenous communities had built into the contract a requirement to train up the local workforce to transfer the skills, the idea being that within one or two contract cycles you no longer had a contract, because you had the workforce there in the community.

How is that - I mean, I know that hasn't been accepted, but how is the work going with the NGOs? Are they working to build up that local capacity or are they sort of saying, well we're not made for that and, you know, how's that relationship going? Because if you don't build up the capacity - - -

MR PATERSON: Absolutely. Commissioner, you're spot on. And I was just at a meeting the other day talking about this very issue where some of the mainstream NGOs were saying that they aren't adequately financially resourced to build the Aboriginal Community Controlled capacity and resources there, so - and these are mainstream NGOs that are committed.

They want to make that transition to transfer the programs and services across to, you know, the capable Aboriginal Community Controlled Organisation, but they just don't have the funding, the extra funding to do it and you know, we would strongly recommend that - if you guys have got any influence in that space, we would strongly support and recommend that it be etched into your report somewhere that funders - you know, government funding agencies, consider that and make a commitment to it.

PROF KING: Just on some of the evidence that was put before us earlier this morning, so we discussed - we had a discussion about provision of services, for example, in the Barclay region and it was put to us it's important to have choice, so that all the money shouldn't be funnelled through, say, a community controlled organisation; it's important to have mainstream services side by side because even some Aboriginal people - - -

MR PATERSON: Yes. Yes.

PROF KING: - - - want the choice. Your response to that? Well, sorry, my response was well, is that practical, given the low population base? Can you actually financially viably have essentially parallel services? Your response to that? Is choice necessary? If choice is economically impossible - well, is it economically possible? If it's not economically possible, how is that dealt with?

MR PATERSON: I might add to that.

PROF KING: All right.

MS DYALL: I think that what we know from the evidence is that self-determination is one of the key things to being able to facilitate wellness and with community Controlled Health Services, like we said in our report, is that that's based around self-determination and around the community having control of the decision making.

And so when - so that's the position that we take. We do believe in partnership, though, and we do believe in the integration of services and that's how we work with comprehensive primary healthcare and if you look at the ACCHOs, then they'll have that integration of services internally, but also integration of services externally as well.

And we have to work that way to create that holistic wellbeing. However, with local decision making, that sits within a community controlled framework and that's our position, self-determination, which then leads to choice and control over their own wellbeing and health.

PROF KING: Any feedback on - sorry.

MR PATERSON: Sorry, commissioner, I might just - yes, just add to what Danielle's responded to. I think in some areas there just isn't any other service provider, so I think another option for those that choose that they don't want the services to be delivered by their local Aboriginal Community Service Provider is that that service provider is resourced so that perhaps they can contract out and that, you know, a service provider may not be available, like you say, in Tennant Creek, but it might be available from Alice Springs or Darwin, that can go and deliver the service that's been asked of them.

And this happens in the Aboriginal Legal Service. As you would appreciate, there's, you know, a court case with two indigenous - between two indigenous, you know, individual - the Aboriginal Legal Service can't represent both of them because of the conflict, so they have the capacity to outsource to mainstream legal providers to do the representation of the other person, so - - -

PROF KING: Yes, that's a really good - - -

MR PATERSON: A similar sort of model, yes. There's precedence already been set there. But we need to think through and get good arrangements, good agreements in place for the data, the medical records of those individuals. You know, because we don't want that disappearing from the local community either, because that person may, in an emergency, have to rock up to the Aboriginal Community Controlled Services Provider. If those notes or that information isn't available on their medical records, then, you know, the clinicians and others that are, you know, wanting to get a bit of a picture of what the last treatment entailed might find it a bit challenging. So you need to work out arrangements and processes about accessing that sort of information of an individual, you know, in those circumstances.

PROF KING: It's a problem Australia-wide. We don't join up Medicare (indistinct).

MR PATERSON: Providers.

PROF KING: Exactly.

MS ABRAMSON: I just had one question. I'm sure I read it in your submission, but if I didn't, I'm apologising. There were a few submissions. The community development program - so in our report, we looked quite hard at placement for people with mental ill health to get people into the workforce, and I seem to remember that there was something about there were a number of problems with the CDP and how it works for - in that mental health space. I might have got this wrong, but I'm interested in that.

MS BURGOYNE: Yes, absolutely. So I noticed in the report one of your recommendations is around evaluating the - under the Jobactive programs and, you know, the others the assessments for, you know, fit to work. But it wasn't mentioned that that should also be evaluated for CDP. So that was one of the recommendations - - -

MS ABRAMSON: We didn't know that. That's why I'm (indistinct) to talk to us.

MS BURGOYNE: - - - that you made – that we made to you, that it would be great to look at that as well because we have heard from CDP providers that those assessments are sometimes saying that people are fit to work when, you know, by all accounts, people who aren't – that they are inadequate, that – again, that they're sometimes not being carried out in a very culturally safe way. But I think even beyond, sort of, evaluation of those medical assessment processes, the CDP program in its current form – and there has been a lot of work done by Aboriginal peak organisations and a whole range of CDP providers over a range of years to push for a reform to try to make some really positive change and there have been a few, you know, positive changes. But overwhelmingly, in - the reports coming back from communities are that you see increasing numbers of people disengaging from receiving any kind of payment at all. I get it's this sort of – I guess that punitive sort of welfare model that's, you know, pushing people to, you know – instructing people what to do and how to live their lives rather than empowering people to do that themselves and there's also, again, big problems with the number of hours that are required of the participants, as opposed to Jobactive which was just highly unequal.

The nature of work sometimes – some CDP providers, they're doing fantastic, you know, really engaging work. At other times it's not providing people with a whole lot of, you know, meaningful work and engagement, and so – yes. What the reports are bringing back of communities is that you are seeing increasing numbers of people disengaging entirely and that is then also leading to less money overall in the community, and again, a lot of – some are things left over, but you know, the stress that that then puts on households in terms of food security, in terms of (indistinct) and those kind of things, potentially, you know, violence, you know, those – you know, these are the kind of things that people are talking about that this is having – you know, that this is the impact that this program is having on communities and without a doubt, that's impacting on people's mental health and wellbeing. So yes, it is a big problem. But there is the – what was the name of the – Fair Work and Strong Communities Remote Development Employment Scheme. So there's an alternative model that has been developed by all these CDP providers over a number of years. They've worked together to say 'how can we do this differently', and it being put to the Commonwealth – so yes, we've also recommended that you guys also support that as an alternative model.

MS ABRAMSON: Thank you. Thanks very much.

PROF KING: Just one final one from me – more curiosity because I was wondering, how's it all going in East Arnhem? Because - is that still in transition or is now – the (indistinct) has control of the relevant health services? Is the transition in – how's it going?

MR PATERSON: Yes, no, it's all completed. The last two were transferred, I think just prior to Christmas last year. The latter half of last year, anyway. Ramingining and Gapuwiyak I think were the last two, so all those clinics there that were former Northern Territory government-run clinics are now under Miwatj, a regional corporation, and - - -

PROF KING: Which is the next region off - - -

MR PATERSON: Red lane, there's the - - -

PROF KING: Yes. Sorry - - -

MR PATERSON: Yes, it's the newly – it's newly established. Well, it's been incorporated for a number of years now and – but just didn't attract any seed funding from funders – government funding agencies to provide the appropriate resources so we can (indistinct) the capacity of the new health service there. They've now got funding. They've got a transition manager, a business manager and a couple of field officers to go out and liaise now and explain to people on Minjilang and Warruwi, Gunbulanya, and it'll cover also the Cobourg Peninsula homelands, Kakadu homelands and Jabiru people living in Jabiru. So it will cover the western – what we call the western Arnhem Land region.

PROF KING: Very good.

MR PATERSON: And right in the middle on its own is the Maningrida, or Mala'la Aboriginal Health Corporation. We see that as a standalone regional health provider because there's over 3000-odd people there in the population, so it's big enough. It's got big, you know – it's – the economy to operate, rather than having to look at – across the – outside to partner up with somebody else. So the economy is of a scale of – to operate as a standalone health – they've got mental health and disability. They're one of our few Aboriginal community controlled health services that provides that as their own disability and aged care precinct, and then obviously we need to all those services, as much as they possibly can, to be on the homelands that are around that area.

PROF KING: That's fantastic.

MS ABRAMSON: I remember seeing something about the aged care because it was quite novel and unusual, so I actually remember seeing that.

MS DYALL: And they have a large Aboriginal work force. Quite a large one. It's really good.

PROF KING: That's fantastic.

MS DYALL: Really positive, yes.

MS ABRAMSON: Yes. Thank you very much.

MR PATERSON: Okay. Thank you, Commissioners.

PROF KING: And next, Sophie.

MS ABRAMSON: You've been waiting patiently.

MS MUNCH: Hi there, hello.

PROF KING: Sophie, if you could state your name and any body you represent or organisation you're representing, if any, and any introductory comments you'd like to make?

MS MUNCH: Okay. Thank you. My name is Sophie Munch. I've changed my name since I submitted that. So I am here on behalf of Saltbush Social Enterprises, where I am the manager of the low-intensity mental health program. So we employ over 65 per cent Aboriginal staff and we have a number of programs. I won't go into that. But my program, which is the low-intensity mental health – so I have a number of points to make. Some of them may or may not relate directly to my role at this organisation, but as a general observation of what the current system could improve on. So they may not be necessarily in the right order. I've just scribbled them up.

The first topic I want to talk about is the Better Access scheme that's not available for counsellors. I am sure this is not a new topic for you guys.

PROF KING: No.

MS ABRAMSON: No.

MS MUNCH: So for me, there are two – I can think of two areas. One is the plain inequity or injustice of the system, and here I actually want to share my own personal story. Between 2002 or 3 to 2007, I built up a very successful private practice in Brisbane, partly because I actually had a Bachelor of Clinical Hypnotherapy and I was a counsellor. So a lot of very difficult cases were referred to me. It's like I was the end-of-the-road therapy for a lot of these patients. So I had a lot of referrals from doctors and psychiatrists, and then when the Better Access Scheme came in, I didn't even notice it until a few years later. By about 2009, my business was more than halved. It was just so awful, and the doctors say to me, 'Sophie, I'm sorry, we can't refer any more to you'. Anyway, to cut a long story short, I had to close my business, and so that is the injustice side.

The second side is the productivity side, which is what this Commission is about. I'm – well, I'll publically state I'm 65 years of age. I've been a counsellor 22 years, so I entered the profession later in life, and I found that a lot of people that are counsellors actually enter the profession quite late in life and I think, you know, the life experiences definitely bring to bear. And it's like - the analogy I will give is if you have a 24 year old university graduate who study sex therapies and she's a virgin she would not be a very effective sex therapist, okay?

MS ABRAMSON: That's the first time that word has been on this transcript.

MS MUNCH: Okay, that's an extreme example of life experiences.

MS ABRAMSON: Yes, I understand.

MS MUNCH: Bringing to bear what the service is about. And within that productivity item I also want to talk about therapy or counselling is essentially an art informed by science. It is not a science. I actually was at a job many years ago where I had a treatment manual and I was told you have to follow the treatment manual but, wink, wink, do whatever you like, this is what the funding required.

Now, you cannot have a manualised treatment for clients and be effective and not lose the client, okay? So you can learn all the therapies under the sun, if you are a cold, blank faced, flat, you know, person that have no empathy you're not going to make it, you know. So that's why I think that to put - to afford certain disciplines the benefit of the Medicare rebate and other disciplines like counsellor not, perhaps - I don't even know what's the rationale, if the rationale was what they studied or didn't study then, that the art versus science will - that will take that down.

But certainly in any case a lot of the other disciplines that are given better access actually study less in counselling interventional skills. Now actually I was a clinical supervisor for a large organisation and I supervised all the psychologists, social workers, counsellors, support workers, across central Queensland, that was my job, mostly on the phone because it's remote.

And I had one psychologist that actually said to me, 'Sophie, I remember the first client that I had, she walked into the room, just sat down and bawled her eyes out and I sat there completely thinking oh, shit, what am I going to say, what am I going to say?' And she then told me that she only did two units in counselling, both of them electives. And yet she had better access and I didn't. Okay, so that's actually go back to actually the first one, I reversed it. That's my first item.

The second item is kind of related. Because of the better access a lot of jobs stipulate that they only looking for social workers and psychologists. And again, so personal experience, I was working in Western Australia and I was acting manager for 11 months and they kept not giving me the job until I - because they kept trying to talk to the powers that be because the job was funded not for a counsellor. I had already been in the job two years, I knew the community well, everything they agree that - anyway that's another story. So I think that instead of just looking at the better access the stipulation for the funded positions need also to be reviewed.

The next item is research actually consistently show that the best outcome for mental health patients would be psychotropic drugs along with therapy yet you see all the clients going to the doctor, they get antidepressants and that's the end of the story. So I just feel that whenever antidepressants and psychotropic drugs are dispensed they should also be referred to some kind of therapy counselling because no amount of chemical change in your brain is going to help you heal the past traumas, it's not going to help you with relational skills, communication skills, decision making skills, parenting skills, et cetera. So that's

another area that I feel quite passionate about.

Next item, I'm rushing. Okay, so the other thing is I've worked very remote, remote and very remote, I worked in Derby and I used to go up and down the Gibb River Road, in the wet season by small plane in the dry season by four wheel drive, and stay overnight and so on and so forth. So a lot of the - I think there is now that push, correct me if I'm wrong, I know eHealth is very big and eHealth is great, for physical problems.

For - you know, like I took nine months before I managed to establish relationships with any of those people, right, I used to sit with them under a tree and just simply yarn. And no therapy, right. And so I think I just hope, I don't know if that's been done, I hope that they're not going to push eHealth type therapy particularly for remote people. But even for non-remote.

Anyway, I don't agree with any web based therapy because even we know that motor neurons are triggered in the personal space, I don't think that any empathy or any - you know, the motor neurons are going to be fired through a screen. And particularly a lot of clients have these four inch little iPhone that their worker give to them, I actually do some remote work, which I just think it is sad that they don't get the kind of service.

Which brings me to the next point. I was actually working for Mala'la, the - I worked there for three years. So we used to have a lot of funding, almost people begging us to run programs, but we could not find staff. So there's two things, is capital investment, right. So I will talk about staff accommodation. We could not employ staff because we had no capital structure and no one funded that, or we couldn't find funding to build accommodation.

And I actually left that job very sadly because I really got burnt out, I was just, you know, me, myself and I, and then later on we found one person who did not require housing because her partner was already in community. That was how hard it was, you know, so that's another area that's outside of this mental health productivity but it's related, is the capital funding.

Even now where I'm working, Saltbush, a great organisation, you know, like - but we don't have a building, I have to do outreach. When you got to a client's house, they've got dogs running around, 10 people in the house and the kids keep coming out, you sit outside and it's really hot in the heat, it's not conducive. We don't have a counselling room because we do not - we're just using the premises that is for another program where I'm housed.

So it just feels that there's this need, there's a great organisation that's really run by a lot, 65 per cent, Aboriginal people for Aboriginal people and yet we don't have the capital structure. So other thing is the same in remote community, is the housing. You know, like Health in all Policies as far as I'm concerned. It's a well health organisation initiative and I think South Australia is the only state that subscribes to what they call Health in all Policies.

Health in all Policies means that they look at how from the very top of the government - they don't look at how just by the health minister but they talk, the departments talk, so housing, education, so on and so forth. A lot of the remote Indigenous communities their disadvantage, or their mental health issues, so totally related to other areas like housing. Housing wait in Maningrida was eight to 10 years.

Meanwhile 17 people lived in a three bedroom house. I mean, I would be fighting - I would have domestic violence if I have to live with 16 other people sharing one toilet. Do you know what I mean? So that's probably outside the scope of this commission's hearing but I think somehow somewhere it can be fed back and take South Australia as maybe an example, I don't know how well or not well they're doing but I know they are the only state, yes. I think that's all I've got from my - - -

MS ABRAMSON: That's quite a lot, actually, Sophie, thank you.

PROF KING: Workforce issues, so you said, you know, the issue of accommodation meant you couldn't employ staff, you were concerned about eHealth - - -

MS MUNCH: Not having that personal connection.

PROF KING: Yes, but then we've also heard evidence about just the workforce issues, particularly in the Northern Territory, they've just started up counsellors and psychologists and psychiatrists, so how do we balance - firstly let me ask a concrete or a more narrow question, if the choice may be between no service or a distant service which may be video based or eHealth?

MS MUNCH: Yes. Well I can actually say that it's almost a waste of money, a waste of time. I have been seeing one person from Wadeye, so our service actually - I just don't feel like first of all that - I just don't feel really connected, and then after three, four sessions now he - the worker couldn't find him and she said, 'Look we've been wasting your time booking the appointment and him not showing up and we're going to have to talk with him, how come isn't he -', and I know that if there was that service or that location, Wadeye, had on the ground counsellors they would be able to engage that person much better than being here in Darwin.

So I hear what you say and what's the choice, I think it's probably better than nothing but if you look at productivity it's probably very close to not much. I don't want to say nothing because for sustainable change, see, I think that therapy shouldn't be, oh, I really felt good, I talked to the therapist today, it should be sustainable because otherwise I become - they become dependent on me and I become facilitator of their continued dysfunction, whereas there should be sustainable change. So that kind of thing cannot happen.

PROF KING: How much - yes, because with workforce shortages it can be very difficult living in communities for outsiders, how much do we depend for progress on local people being trained up to be counsellors and so on, is that one way to try and answer the - - -

MS MUNCH: Well, yes and no, the theory, in theory, yes, but in practice probably not. And the reason is because a lot of the very disadvantaged people in very remote places they have multiple very complex trauma, they have very high complex needs, to have the kind of counsellor that will actually be able to help them make a difference, a sustainable difference, you likely looking at someone that's, you know, gone through a lot of training, been trained in multiple models of therapy and so on and so forth.

I'm not saying that the local person is not capable of doing that but in order for them to actually attend university, it's just a very long process and it's like if you're stuck in that disadvantage it's harder to break out of that and actually accelerate and excel, you know. So for them to - but I absolutely am passionate about empowering local people in any capacity, meet them where they're at and develop them where they're - and that's all about community development, right?

PROF KING: Yes.

MS MUNCH: But to get to that level will probably take a very long time.

PROF KING: It's a long process.

MS MUNCH: Yes.

MS ABRAMSON: Thank you so much.

MS MUNCH: Thank you.

PROF KING: The next one is Gally McKenzie. Gally, would you be able to state your name and organisation and any introductory comments that you would like for the transcript?

MS MCKENZIE: Of course, Stephen. I'm just going to put my phone on the loudspeaker so just bear with me.

PROF KING: Of course.

MS MCKENZIE: Can you hear me?

MS ABRAMSON: We can.

PROF KING: Yes, that's fine.

MS MCKENZIE: Thank you. So I'm Gally McKenzie, I'm talking with you today. I'm the chairperson of the Australian Association for Infant Mental Health. We are a national association and we have branches in every state and territory with one developing at the moment in the Northern Territory. We have I think about 430 members which comprise of health professionals in the main and early education people, policy makers, yes,

comprise, and I think - what else would you like to know?

We're a company limited by guarantee, we're not for profit, we're run by a board of directors and an executive who are all senior infant mental health practitioners who volunteer their time, expertise and resources to AAIMH. And each branch, that is the state and territory branch, also has a management committee who likewise their members volunteer their time and expertise and resources.

And we're each with the Awards Association at Torrington Mental Health. Yes, and just as an aside, there were (indistinct) conference for (indistinct) mental health is actually happening in June this year, and it's called Creating Stories in Interim Mental Health Research, Recovery and Regeneration. It would have all the nine (indistinct) and many hundreds of committed practitioners from a practice at Gove.

How about I just give you a little line about what infant mental health refers to?

PROF KING: Yes, that's fine.

MS MCKENZIE: Okay. So it's the developing capacity of the infant and young child - that is from pregnancy to three years old - to experience, express and regulate emotions from close and secure relationships, and explore the environment and learn, all in the context of the care giving environment that includes family, community and cultural expectations.

Because infant mental health may be defined as a multidisciplinary approaches to enhancing the social and emotional competence of infants in the biological relationship and cultural context. It requires expertise and conceptualisation from a variety of different disciplines and perspectives, including from research into the good practice and public policy.

And our mission is to help give infants, young children and their families, the best possible start in the important early years of life, by improving professional and community understanding that infancy is a critical time for the development of emotional, physical, cognitive, social and mental health.

So, that's the context from which I come to speak with you. I'm a clinician, I'm a psychotherapist, and have been a clinician for over 40 years.

PROF KING: Okay. You've shot through some notes, so thank you for those. Now, you've got some comments on a number of our draft recommendations; I wonder if you'd like to just briefly run through those comments, particularly obviously the ones relating to child and adolescent mental health?

MS MCKENZIE: Thank you, yes. First of all, I congratulate both of you and your colleagues and your team; your draft report is really extensive and inclusive, so that's been

really rich to read that and note that approach. I will comment on one of the fact sheets on children, childhood, children and young people, which states that:

Early identification of risks in children and young people enables intervention and prevention of mental illness.

With which we agree. This can significantly improve mental health, and social and economic outcomes. It says:

For many children, pre-school or school is the place where risk factors for social and emotional development are quickly identified.

However, AIM would like to argue that infant mental health-oriented maternal and child health nurses are more than aware of mental health challenges, if not disorders, in the infants and/or the parents that attend their clinics, or are seen at home visits.

The potential to improve mental health or allay the worsening of challenges exists for infants in child health clinics throughout the country. Therein, AIM recommends early identification, not only by maternal and child health nurses, but also by midwives and general practitioners, who are aware of infants at risk of developing mental health challenges from their earliest days.

And so to that, we have additions to the existing draft recommendations.

PROF KING: Yes, please.

MS MCKENZIE: So for draft recommendation 8.2, Child and Adolescent Mental Health, and we recommend a long-term commitment to the provision of hospital-based and specific mother/baby-based known in the kids ward as the MBU, in all states and territories as a priority. I will speak to that some more.

So this also links with draft recommendation 13.3, Family Focus and Carer-Inclusive Practice. "There is no such thing as a baby," John Wintercock, who was a British paediatrician and psychoanalyst, said:

Alone with a baby alone doesn't exist. What exists is always a nursing couple. A baby trusts someone to take care of him or her.

He also introduced to us the concept of a holding environment; in other words, infant wellbeing is contingent on their carer or carers' wellbeing. AIM recommends family-focused and carer-inclusive practice, including, as I mentioned, mother/parent, baby or toddler units in all states and territories to preserve and enhance secure attachment relationships as the bedrock for infant mental wellbeing.

PROF KING: Yes.

MS MCKENZIE: So for draft recommendation 11.1, the National Mental Health Workforce Strategy, we would like to add, AIM recommends that the Workforce Development Program, which is being undertaken for the National Mental Health and Suicide Prevention Plan include consideration of our youngest and most vulnerable persons. The infant idea is yet to be born infant, in other words, it is unusual today.

I have included in my written notes a section from the UK House of Commons Health and Social Care Committee. You've got that?

PROF KING: Yes, we've got that, yes.

MS MCKENZIE: Right, so I don't need to go through it?

PROF KING: No, no, that's fine, we've got that.

MS MCKENZIE: Thank you. Okay, so I went through some more of what you've collected as recommendations. For draft recommendation 11.2 Increase the Number of Psychiatrists; AIM recommends specialist infant mental health-trained psychiatrists be available in all, and especially in the non-metro areas.

For draft recommendation 11.3 More Specialist Mental Health Nurses. AIM recommends specialists infant mental health training, and regular, consistent, reflective supervision be available for mental health nurses in all areas, and especially in non-metro areas.

For draft recommendation 11.5 Improve Mental Health Training for Doctors, AIM recommends clinical infant mental health training and consistent, regular, reflective supervision for doctors be available in all, and especially in the non-metro areas.

For draft recommendation 11.7, Attracting a Rural Health Workforce, AIM recommends the inclusion of consistent, regular, frequent, reliable, reflective supervision, not only as a workforce development strategy, but as a workforce retention strategy.

PROF KING: Yes.

MS MCKENZIE: And now I move to the finding 16.1, Prevention and Early Intervention to Reduce Contact With the Criminal Justice System, and finding 16.4, Health Partnerships; AIM recommends that the Family Court Judiciary are asked to ensure they gain a basic understanding of the importance of decision-making appropriate for infants and very young children, and why this age would be different even from children three years and older.

The Family Court Practice and Procedures, The Rights of the Child To Be Heard, in 2010, recommended the Family Court should consider implementing a training program for judges, and with state and territory agreements, magistrates exercising Federal Family jurisdiction, a more inquisitorial approach to determining the best interests of the child. AIM strongly supports that recommendation, and that such training be on the latest knowledge of infancy, the impact of environment and type of caring relationship.

Good infant mental health and wellbeing is the prevention of later social mental health, intergenerational economic and justice problems in adults, and in adolescence.

With draft recommendation 17.1, around Pre-Natal Mental Health, AIM concurs with the recommendation.

For recommendation 17.2 and 17.3, Social and Emotional Development in Preschool Children and Social and Emotional Development Programs in the education system, AIM recommends the inclusion of ages zero to five (indistinct) be used, as preschool is often interpreted to mean the immediate years before formal schooling. AIM recommends that (indistinct) professional development for workers and professionals that consistent, regular, and reliable, reflective supervision be integrated into the broad workforce, that is, the clinical and non-clinical workforce - for example, early childhood educators and teachers who work with infants in the zero- to five-year age bracket – as a means of ensuring best practice and accountability.

PROF KING: Yes. Gally, can I get you there – just to ask you on that one, we’ve received significant pushback on considering emotional threshold – emotional development in preschool or in zero- to five-year-old children, and there is a view from certain sectors that that will lead to over-medication of children, that it will lead to abuse by GPs and pharmaceutical companies. Do you have concerns in that area? Should we have concerns in that area? What safeguards do you think would be needed in that area to make sure that children who – and families, because it’s really – zero to five, it’s really families in need of support – how do we make a clearer – how do we create the safeguards for that type of recommendation, or those sets of recommendations?

MS MCKENZIE: For sure. Well, AAIMH together with the World Association (indistinct) the use of the DC: 0-5, which is the diagnostic classification for infants from age zero to five. So that is a diagnostic classification manual which clearly articulates the various presentations, I guess, that would concern clinicians. It also includes recommendations as to treatments and certainly medication or any form of treatment that is not relationally based is not the preferred option for this age group. So I think with ever season, there is – yes, no, I don’t think it, I know it. There is concern in particular around children who might exhibit what is called attention deficit hyperactivity disorder or autism or the various presentations that are kind of grouped under those headings. Infant mental health has a very different perspective on some of these presentations. The main thrust of infant mental health work is around relational work. It’s around the attachment between the little one and his or her primary carers as a vehicle for treatment. So in other words, AAIMH’s preference and its main modality for working is actually in a relational way, rather than a, you know, pharmacology or even behaviourally-oriented interventions.

PROF KING: Any thoughts on how we make that – because in a sense, that’s also what we were thinking, that it’s relational-based. Any thoughts on how we make that clearer in our recommendation or in the text, or – because of – I mean, we have received more submissions post-draft against social and emotional wellbeing checks for zero and five – to five-year-olds than any other issue.

MS MCKENZIE: Interesting. I'm glad to hear people are concerned for little people though. Okay, well, perhaps some documentation that might be worthwhile for you guys is the AAIMH competency guidelines for culturally sensitive relationship-focused practice promoting infant mental health. We call them – we just call them the competency guidelines. So Stephen and your colleague, the space infant mental health is, as I mentioned earlier, an interdisciplinary field and we work together in teams to work with little people and their families. So in that, we have now got a set of competency guidelines that is – that are relevant to all workers that work with infants, and that's whether they're psychiatrists, GPs, whether they're early childhood people – nurses, doctors, speechies, occupational therapists et cetera – and what we recommend is that workers who work in this field be able to demonstrate that they are actually endorsed to work in the field. So in other words, that they have undertaken and meet the competency required to work in the field. Yes, so processes are currently underway here in Western Australia – we will be the first state, or the first place outside the USA to actually be able to endorse infant mental health practitioners. In other words, to accredit them to work in the field. Yes. I don't know if that's of any help to you at the moment.

PROF KING: Yes, no, that's good.

MS MCKENZIE: Yes.

PROF KING: Okay, thank you. Sorry, I interrupted your flow there.

MS MCKENZIE: Please interrupt me, that's fine. I think, in fact, I've covered maybe – probably most of it, at least what I've written down here. We talked about the (indistinct), so I've mentioned the DC: 0-5, the manual or the training – sorry, the diagnostic manual, yes. With regards to 21.1, the cost of suicide and non-fatal suicide attempts is high, we would recommend consideration of the UK report, the one I mentioned earlier that I think you guys are very familiar with. But I'd just like to draw attention to a line – a couple of lines in this which indicate that individuals with four or more adverse childhood experiences, which are known as ACEs, are at a much greater risk of poor health outcomes compared to individuals with no ACEs. They are also 30 times more likely to attempt suicide, and the UK report recommends - intervening more actively in the first 1000 days of a child's life can improve children's health development and life chances and make society fairer and more prosperous.

PROF KING: Okay.

MS MCKENZIE: It also, of course, speaks to social stresses, which of course impact children's and families' wellbeing. Okay, so there's one other point I have here. With regard to government responsibilities and consumer participation, (indistinct) to inject genuine accountability for system outcomes to clarify responsibilities for program funding and delivery and to ensure consumers and carers participate fully in the design of policies and programs that affect their life. So this might actually link to what you raised earlier with regard to people's concerns about little people being medicated. AAIMH recommends

that scope of practice is clearly articulated, appreciated and supported by all professional workers, educators and employers working within the infant mental health field. I think you will well know that there are practitioners or workers who are tasked with working in non-government agencies, perhaps in rural and remote locations, who are faced with enormous responsibilities and safety issues with regards to children and their families. But these workers and these agencies are not always adequately equipped to deal with the complexities.

So we're concerned that workers who work in these arenas be adequately supported to appreciate always the boundary of their practice and that the agencies also be aware of the boundary of what is possible, and that channels be opened for these agencies to be heard with regard to their concerns – but not just heard, but that action be taken to support the families via supporting the workers in these agencies in order that workers themselves feel safe in their work or/and in their workplace, and thus can offer safety for infants and families in their communities.

PROF KING: Okay. Thank you very much for that, Gally.

MS ABRAMSON: Thank you.

PROF KING: Thank you for your time today. That's been really useful and helpful.

MS ABRAMSON: Thank you very much.

MS MCKENZIE: Thanks for your buzz and thanks for all your great work.

PROF KING: Okay, and last but not least, Anne. Anne, if you would be able to state your name, the organisation you're representing and any opening comments you'd like to make them in the transcript.

MS GAWEN: Hi, my name is Anne Gawen and I'm the CEO of TeamHEALTH. I would like to acknowledge that we meet today on the lands of the Larrakia People and I would like to acknowledge the elders past, present and emerging.

So I'm the CEO of TeamHEALTH and we're a non-faith based mental health organisation. We believe the largest in the Northern Territory mainstream organisation. And our focus is on psychosocial supports for Territorians. We provide services and support to Territorians who have a mental illness or who are vulnerable and disadvantaged and have fallen through the cracks. And we've been doing so for 30 years.

What this actually looks like is supporting people when they come out of hospital or when they become unwell to regain confidence and connections. It's gaining safe and secure housing, getting a job, gaining skills, or whatever it is in their journey they want to achieve. It's listening to and understanding what an individual wants, utilising their strengths through using outcome stars and other tools and helping them create their best life. What we acknowledge is that a valued life looks very different from everyone.

So I'm thinking you guys have had a pretty long day and much of what you've heard is probably what I'm going to say so I'd like to just talk from my perspective as a new person up in the Northern Territory and some of the experiences I've had up here. And also my experiences in working in the NGO sector as a leader for over 25 years and how that translates to up here.

I guess the four key things I want to talk about is it really is different here and I'd like to talk about that a little bit more. Secondly, that focus on psychosocial supports. We keep hearing it, the Productivity Commission has clearly said the problems and solutions like beyond the clinical areas yet what exactly does it look like, and I feel that the commission's report maybe didn't engulf that enough. And you actually said that last week.

MS ABRAMSON: Yes.

MS GAWEN: So what does that actually mean? I'd also like to talk about the absolute need for accommodation and what TeamHEALTH are doing in that area and what - after the conference last week where I saw you I feel like we're doing really well and I'd like to share that experience. Also I'd just like to talk a little bit about our partnerships with some of the Aboriginal controlled organisations, I haven't put that in our submission but I just thought from - - -

MS ABRAMSON: Absolutely.

MS GAWEN: - - - what I've heard today you might find that interesting.

MS ABRAMSON: Yes.

MS GAWEN: Remembering that I'm talking as a person who has been here for five months, and so I'm by no means an expert in any of those things. I'd just like to start with the territory's difference. As soon as we say that people's eyes glaze over. It really is different. I've been working here for a long time and I've heard many, many stories. I guess I'd like to give you an example of how different it is, so we run programs out at Gunbalanya, so you've heard that mentioned a few times, so that's about 80 kilometres across Cahills crossing, the most notorious crossing in the NT, I think, that's what people tell me. And an Aboriginal community out there and we have four Aboriginal staff that run that service, that's funded by DSS and it's a wonderful service.

When I went out there to visit the Aboriginal staff and my air conditioner broke down, but that's another story, they were talking to me about the work that they do. A wonderfully funded program by DSS I have to say. But one of the stories they told me of was that with an Aboriginal boy, a young man about 15, 16, and he simply would not leave his room, his house. And so after they'd worked with the family for a long time and they talked to him they finally convinced the family get an assessment from the Top End Mental Health Service.

And so they met the lady enthusiastically, she then came to the house, she was a white woman with purple hair and earrings. Like that's okay, but it wasn't okay for the family. And so the family sent her away and that was it. So basically our staff just worked with this boy one on one every day, half an hour, an hour, showing him somebody cares, there's a focus. The outcome from that was he eventually returned to school, he eventually gained support in Darwin. He's now two years down the track he's come out as a bisexual man who is functioning out at Nhulunbuy.

So a successful story that to me made my heart sing, like that's what the difference is about. And they have a myriad of stories like that, that's just one. You know, we were there after school, we were sitting in the room, 30 children were there and they said, you know, 'Anne we can't go out and say we're here to talk to you about your child's mental health concerns or your mental health concerns', what they do is they run programs after school, safe programs, and when parents come in they say, 'Do you want to have a chat?' You know, 'What's happening with you?'

And they do that very informal but really supportive program. One of the things they were doing was working with a child who needs monthly injections, and I can't remember the illness, but if he doesn't get it he'll die, and so their focus is around talking to the family about the importance of that. Taking them to the shops, talking with the mother, the child, sorting out the school, he'll be away from school, all of that, you know, really practical things.

And this program is flagged with DSS for its lack of reporting. So there's an alert, apparently. So, you know, as a new person in TeamHEALTH, you know, in other states I'd go I don't care, get the stats, I can't say that here. So we spoke and we spoke and we spoke and in the end talking to the local staff and our Katherine team we decided that we would send a Katherine team up, two staff, one Aboriginal and one non Aboriginal, to simply just sit with them for two days and get the stats in. Great.

Four times they attempted to get out there; the first time they were half way there, so it's sort of a 300 kilometre journey from Katherine, the first time there were five deaths in the community out there in one car accident that the community was shut down for two weeks; the second time there was another death, the community was shut down again; the third time they'd actually got to Jabiru, it was the wet season so you have to fly from Jabiru into Gunbalanya and the winds were too bad the planes couldn't take off they had to go back to Katherine.

So we missed the reporting deadline and we're still flagged. I've never experienced that before, I've always thought there's an answer, there's a way you can get this stuff. So the cost of that to us as an organisation, you know, three times getting people out there, flying them across, two people then leave the Katherine office. So to me that's the difference, I've not had to experience that as a CEO before. And the cost of that, it's hard to actually show what it is but it's significant.

So when you hear about, gee the NT is different, 75 per cent dirt roads, really remote

communities, that's what it means. It means we have to rethink the way we do things. And does that mean that, you know, we have to support those Aboriginal staff but they just said, 'We don't want to do stats, it's not our thing, we just want to work with people', so how do you manage that? I guess that's the challenges and the complexities for me in the NT and that's where we need a little bit of support. But I can imagine in Canberra DSS stats they look at Gunbalanya, what? No way, you know, they don't have enough people.

PROF KING: So is one way of getting around the - so, I think you were here for the earlier discussions about the money going through the ACCHOs, is one of the ways to get around what is a program by programs of democracy in Canberra is to say well the money starts with the ACCHOs and then they can make decisions about services and so on but it's a local responsibility rather than a Canberra responsibility?

MS GAWEN: I don't think so. But I don't actually - I'm not an expert. What I can tell you is that we have a relationship with Mala'la, who is the Maningrida organisation, so we offer psycho/social supports with them. And we talk to them a lot about how we do that and how they're supporting us and they have simply said, 'We are at capacity, we can't do any more', but the PHN want this program to happen so we actually give them a percentage of our funding to give us some cultural competency support, some reputation support, and they pick us up from the airport, our staff, and they give us cars and an office space.

And we talk to them monthly about what's happening in the community and where things are at. So to me that's a really successful partnership. But they're a fairly developed organisation in that they've been operating for a long time and they understand when they're at capacity and they've asked us to help. The other partnership that we're working within is in Katherine, so if I jump to another topic?

PROF KING: Please.

MS GAWEN: The supported accommodation is just absolutely critical and I love the model we have up here, which I will talk about later, but a report that I've got about the gaps in Katherine in the mental health services are supported accommodation. And nobody has been able to fill that gap. Well that's what we do and we do it well. So we've actually been asked by an Aboriginal controlled organisation would we consider working with them to set that up. And I said, 'I can get you the money and I'll make sure we get the money, let's do it together'.

But I think what it means, let's do it together, is let's actually do it together, let's not you sign an MOU to say we support each other and then it goes in the drawer and you never see it again, we're actually going to we're now developing a budget where they will staff some of it, we will staff some of it, we'll offer the mental health expertise, they will give us some of their accommodation, offer the cultural competency, give us some Aboriginal staff because we don't have enough down there.

So to me that's a true partnership. And we're doing it together so I don't know who is in control of it. We'll actually have a look at, well, who's contributing the most and let's do it

together, let's do a true partnership. And to me that's the way of the future. And together we are working with the Aboriginal health organisations down there, and I've met with all of them so far and said, 'Is this something that you want?'

And absolutely, they've all told me, 'We could give you 10 people tomorrow to go into that supported accommodation, just set it up, we don't care who runs it, just set it up'. But, you know, 'Do it in a way that the community are going to accept it'. So our partnership, we would never do it on our own in Katherine.

MS ABRAMSON: So, Anne, is part of that model there that you're also building training competency amongst the workforce there? So if the other organisation has some people who would like to work in housing, for example, but they need to be trained, is that something that you're supporting?

MS GAWEN: Yes, look, that's something we're looking at and we're in the partnership with the mental health expertise and they're in the partnership for their Aboriginal competency and understanding of the culture. And it's actually a drug and alcohol service, is what they do as well. So will talk about how we can share our staff because it will just increase both of our capacities, which is really important down there.

MS ABRAMSON: Yes.

MS GAWEN: And then we'll look at some mental health and community services pathways. And they will look at other pathways for us. So no one is stronger or helping the other one, you know, this NGO is going to help the ACCHOs, we're helping each other and it's actually about us working together to get the outcome for the community. So for me from an outsider it's about what best partnership works rather than having these hard and fast rules about this money can only go to this person and this money can only go to this person.

MS ABRAMSON: So if you thought of that from a big design point of view, which is where we come from, what does the funding model on the ground look like to enable you to run that model without having to reapply every 12 months and the funding is in that bucket and you're cobbled together all the buckets, so what would it look like?

MS GAWEN: Yes, that's what I'm doing. It would look like a big picture model where needs are identified which it clearly is there, and where tenders go out that identify the needs and where partnerships are necessary to achieve - I'm not answering the question very well, I'm sorry.

MS ABRAMSON: Yes, no, I know what you're saying, what you're really saying to us is if you want to provide those services on the ground get the funding to what we're trying to provide, don't think of it in terms of housing is only a small component, mental health is only a small component. I think you're encouraging us, correct me if I'm wrong, to think about well what is the service overall that's been provided, pool the money for whatever set of work and then ask the people to deliver. And be evaluated - - -

MS GAWEN: Absolutely. And in this situation we're driving this, the two organisations are driving this from a Gap report.

MS ABRAMSON: Yes.

MS GAWEN: And one of the lovely things up here, and I'm not happy to go onto the record, is the NTG, are responsive, you know, even though there's a lot of press about their economic state, like they actually want to do the best for the organisation so I think that shift around we're all in this together, this is a really critical gap, and I've actually just met with the minister this morning, this is a critical gap, we're going to do it, who is going to fund it, like we have to make it happen, and we can show you the business case to make that work. And to me that's something that is a great thing about the NT, I feel like we'll get it, I think we - - -

MS ABRAMSON: It's more flexible.

MS GAWEN: It's more flexible, yes. And I guess there's trust in the NGOs that they can do what they need to but also, you know, in partnership with an Aboriginal controlled organisation, which is critical. So those partnerships are really critical. If I talk about our supported accommodation, our partnership in Darwin is with the Top End Mental Health Service and we actually have a great relationship with them.

MS ABRAMSON: And I'm assuming that that is for - it's not just for Aboriginal Australians, that supported accommodation?

MS GAWEN: No.

MS ABRAMSON: That's for everybody?

MS GAWEN: So that's for everybody, yes. So we have about 48 per cent of our participants in that are Aboriginal people. Others are 25 per cent core people and then - you know, diversity. So that is a great model and the reason, you know, thinking about last week why it's such a great model, is it's a great model because of its flexibility. So we - I'm sure you've read in our response, that we built a \$5m facility - it's not a facility, accommodation services, with the help of the Federal Government a couple of years ago and it was opened a year ago and we're just transitioning people in it and everybody is excited about our option.

But as we've been transitioning people in it we had five spare rooms when there was news reports plastered across the NT News that there was a massive critical shortage in beds in hospitals. So went to the NTG and I said, 'It's not okay, we have these rooms, let's talk about what can happen with them rather than we sit there with our pristine rooms with nobody in them while we're transitioning across'. So the NTG were really great and we set up an interim model that relaxed some of those eligibility issues that are plaguing this sector, I think, about someone can only come in if they have a case manager, if they're not

drug dependent, if they have this and this, and it just stops people from getting well.

So the model was about there are some people that need to be in hospital but there are others who were not happy to say yes they're okay to go to community but they don't need to be in hospital, so we're taking a lot of those people and it's working really well because they're getting that step down supported accommodation. It's usually just for short term and it's usually just they need help to get a few bits and pieces sorted.

MS ABRAMSON: And so what does the supported accommodation look like, you've got somebody on site 24/7?

MS GAWEN: Yes, 24/7, so there's somebody on site 24/7, and each person has a focus on their recovery goals and what they want to achieve and for some people it's very simple and for other people it's a really extensive recovery model. And then the other lovely thing about our model is the NTG fund, Department of Health fund a recovery assistance program for us so we tap that into the accommodation service. So as soon as somebody goes in, when they're ready, they then get a recovery assistance worker who can work with them about whatever it is that they want to achieve but long term if that's what they need, which to me is the essence of non-clinical support.

MS ABRAMSON: You've got one - which is a wonderful initiative, you've got one of these models, but I imagine there's a huge need and that's just tapping the surface?

MS GAWEN: There's a huge need. And we're very successful in Darwin because we have the supported accommodation and three different models in that, we also have community housing, we also have other housing stock that we can use, we then have the recovery assistance model, we then have our Child and Family Early Intervention if that's needed. So a wonderful supported model, we work with Top End Mental Health Service extensively around that, if things get acute we have processes around that, so we're not relying on psychiatrists who see them once a fortnight but we do all the work in between.

You know, we have psychologists that operate independently out of our premises if that's needed. But usually we're finding that people just want an ear, they want to talk, they want someone who understands so we try and - we have a high proportion of people with lived experience in our staffing teams, because that's what to me is, you know, what was talked about in the Victorian Royal Commission, they kept referring to the middle ground. You know, where's the middle ground? That's the middle ground to me, it's that support working through your journey with someone to focus on recovery. And then if they have a severe and consistent mental illness we then refer to the NDIS.

MS ABRAMSON: Yes, I was about to ask you where that line was that – yes.

MS GAWEN: So to me, the NDIS is an absolutely wonderful scheme for severe and persistent people with mental health issues, not somebody who presents at hospital that just maybe needs a bit of help to get on track, you know, and that's what I was explaining to minister files today. I fear that there's this thinking that 'oh well, the NDIS is going to take

away our responsibility to the mental health sector', and I think we'll see in Victoria that that's what happened, and it's just not. It's simply not, and particularly in the NT with such complexity. So I guess my mantra is really urging me into government. It's not the answer – the NDIS is not the answer. It's part of the answer, but it's not the whole answer and it really goes against the recovery goals and the mental health principles that I think we're all trying to work towards. Bearing in mind, there are some people that will be on the NDIS that will be better on the NDIS, and we will always support our people to get that if that's what they want.

MS ABRAMSON: What about – and it's a really good point that you've made. The Commonwealth had a number of program cuts in recovery, (indistinct) and de-funded, but then they had to – they realised what the problem was. So would your view be that we need to keep that – those funding streams?

MS GAWEN: Absolutely, and I think you'll see in my report – I could whoosh through all my papers or you could just look at the report. So the money that the PHNs have now got for that is population-based and it's ridiculous. I think we said it would cover eight people in the remote areas of the NT, and that's not – you know, what was the promise for the NDIS? No one would be worse off? They're clearly going to be worse off with that sort of money. So I just – I'm not sure what happened there as to why that was deemed as an acceptable level. But certainly, the need for the Commonwealth government to fund mental health services is really clear and not just, you know, this site's the NDIS, that's the NDIS.

MS ABRAMSON: Thinking about – like, it's not really your space, but we've had a view about governance which is that we put up a model which – we called them regional commissioning authorities, and in our model we presumed what we wanted, that those organisations be able to commission the type of services that you offer. So that was kind of the model that we thought of. So in the current environment, do you get commissioned by the PHNs to provide the psychosocial – I think there's only one PHN in this area?

PROF KING: Yes, one for the area. Yes.

MS GAWEN: Yes, there's one. Look, if I just answer your question generally, the national models just – I don't think would work up here. There's just the one – I understand and we've always heard about the one-stop shop. Are they actually effective? I'm not so sure and I think – like, one of the really interesting things I found when I was – I met a – I had a meeting with some of my Aboriginal colleagues and my mainstream colleagues about the productivity commission report and what we were going to respond, and somebody said, 'well, you know, here's another white middle-class report out of Sydney', and I go, 'is it? What do you mean?' That was – and I'd been here a month, and now I see what they meant. It's – you know we were at those meetings last week and they were talking about, you know, workers – the HESTA lady was talking about workers and their superannuation and, you know, the significant need for workers with a low superannuation, and I understand that that's a significant need. There are homeless, and I just think – and then I look at what happens here and I go, 'gee, you know, we're just really different', and

yes. The messages I got from the board is that that's not a great message, and I go, 'I'm going to keep saying it because I really think it is'. It's – we're really different and, like, can your national model actually take in all of the different variances, particularly in things like the NT. I don't think so.

You know, from my – I've worked in the NDIS a reasonable amount. That's about scale. You know, it sets minimum staffing levels based on the ability to get scale. You can't do that here. So you look at – you know, there are parts of the market in the NT that are flooded and they're flooded because they're the services that make money in the NDIS and there's others that just have no gap – just have, you know, no services because you simply can't make it efficient. So, you know, I've been talking to Miwatj – not the CEO, who was away, but someone else – about coming out – TeamHEALTH needs to come out to Nhulunbuy and set up some NDIS services because no one else is, and we want to work with you around doing that. So you know, we're also looking at that. But making that work with the current model of the NDIS, we're just like, 'gee, you know'.

PROF KING: The process doesn't (indistinct).

MS GAWEN: The process just won't work, and then how do we know that the market is there? There's not enough stats to show us and that's what – also what I'm finding up here. I'm not getting the stats to show – everyone's saying 'there's a need, there's a need'. I'm like, 'where's the need?' But it's just really - - -

MS ABRAMSON: Well, we're actually thinking about that in another context. We've got an inquiry which our Aboriginal commissioner, Wal Mokop, is chairing which is about evaluations and – evaluation in that space. So it's kind of a broader issue than just the programs that we're looking at.

MS GAWEN: So I guess for me, the key issues – or for TeamHEALTH, the key issues are, you know, the NT is different. Like, I think we said in our report, you know, we have five different quite extensive accreditation processes we have to go through that I've never experienced in other organisations. You know, the general 'I've just finished my MBA' and, you know, the big hoo-hah is you just get your niche and you go for it. Well, we wouldn't be sustainable if we did that here. We have to look at different markets and different opportunities. Like, we always make sure we do them well, but it means we just need – you know, when I started I said, 'our admin's too high', and now I understand why. It's because we have, you know, these five accreditation, quality-assurance things that we need to do, it's our diversity of staff, it's upskilling our staff. You know, before they start, we need, sort of, four or five lots of training that they need to do and then they might move in three months because their partner's moved for – in the RAAF and they've gone, you know. So just little things like that that really do impact us as an organisation and our strength as an organisation.

PROF KING: So just one thing, on – because you mentioned Nhulunbuy, I'm not sure if you've been here long enough to answer my question, but I was wondering – because East Arnhem has been a, you know – I don't want to say an experiment, but it's been a change

in the way service is deployed over there, and I was wondering how that's worked from TeamHEALTH's perspective. Has it been good? Has it been bad? (Indistinct).

MS GAWEN: Look, I really couldn't comment. We have no services in East Arnhem Land.

PROF KING: None, okay.

MS GAWEN: No, no services. I was actually born over there, but that doesn't help you at all, and so we're actually just looking at the market now at the very early stages. So yes, I really couldn't comment. But we are really - - -

PROF KING: Okay. No, I didn't realise there were none.

MS GAWEN: No, no services. But we are certainly - we're committed to working with Miwatj to look at, you know, opportunities there.

MS ABRAMSON: I just had one final question. I'm very grateful for that, that you've come along at the end of the day when you have a serious day job, as do other people. Workforce: we've heard a lot about that, particularly the (indistinct) workforce, the (indistinct) workforce. What type of views do you have on that and what makes a difference?

MS GAWEN: I think there's some real positives about the NT workforce, but I think there's also some real difficulties in it. So the NDIS with the set market rates, that makes it exceptionally hard because there are some services you simply – we have to subsidise to offer them as an organisation or we couldn't, based on their unit costings, and it is exceptionally difficult here. Like, we are seen as a really good employer and I think our retention rate is two and a half years, you know. Something like that.

PROF KING: That's a pretty big turnover.

MS GAWEN: Pretty big turnover, you know.

PROF KING: That's about 40 per cent per year, wow.

MS GAWEN: Yes. So it's big, and we, honestly – coming up here, one of the things that I was told was 'gee, how are you going to fit into the Northern Territory? You like processes and structures and you like things – you like frameworks'. It's wonderful. You know, we were a lovely organisation that is really structured and focused and has lovely – you know, our focus has been on supporting our staff so that we can be seen as a good employer, which we are seen – but you know, two and a half years? Like, wow. So we're really struggling with that and it means the CEO is really struggling with that, and we also – you'll see our senior leaders are fantastic. We're trying to get diversity because a lot of them are, you know, middle-aged women who are pregnant and having their second and third babies. So I've put a ban on all babies now. Clearly I haven't. Just - - -

PROF KING: No, I know that that was a joke.

MS GAWEN: So those challenges are difficult for us. The Aboriginal workforce is something we really need to strengthen as an organisation and I'm really keen to talk to some of our partners around how we do that. But it's tricky, you know. So our rule is you need Ochre cards to work with us and you need a current licence. So you have - - -

MS ABRAMSON: Sorry, what was the first thing you said?

MS GAWEN: You need an Ochre card, which is an NT-specific card.

MS ABRAMSON: Yes.

MS GAWEN: And many of our – we have some wonderful Aboriginal people that we could employ but they don't have that. We don't have Aboriginal people in senior management roles. We would love to have some Aboriginal advisory staff. It's difficult to have that. You have to get to a scale to be able to afford those sorts of initiatives, and that's what we're looking at. That's how we're trying to strengthen that. We – I think you'll see in our report, the amount of money we spend on training is significant. You know, we pay above award in many of our instances. I mean, all the NT services that I'm familiar with have extra holidays. So it just costs us more up here and we need to do that to attract the staff that we get. So yes, it's really difficult, and how you actually acknowledge that in the big service system model, I'm not sure. But certainly having minimum – having models set up on an hourly rate is not the way, because that just really impacts us.

MS ABRAMSON: Thank you.

PROF KING: Thank you.

MS ABRAMSON: Thank you very much.

MS GAWEN: Okay, thank you. So would you like - - -

MS ABRAMSON: It's been really interesting, thank you.

MS GAWEN: Yes, I'm sorry that you've probably had a very long day.

MS ABRAMSON: No, but the personal – the stories of what you're actually doing are really helpful and, you know, they're great models. So what we have to think about is what you said about the Territory being different and how scalable things are. That's what we're thinking about.

PROF KING: It's also – yes. It's also important, because you've had experience outside the Territory and come back - - -

MS ABRAMSON: That's right.

MS GAWEN: Came back in, yes. Look, and I can't highlight enough the psychosocial supports. You know, I think we've always gone to the 'we'll just get you more clinicians and we'll just put more hospital beds'.

MS ABRAMSON: No, we're - - -

MS GAWEN: And we're clear that's not the way.

MS ABRAMSON: Yes. It's like I said the other day, and - our report came out with a - it looked like we hadn't really thought about that, that we were clinically focused. But that's not what we intended, so we will think about that for the final report.

MS GAWEN: Great. So I have - I've just got a little bit more information, so the position statement from TeamHEALTH, and just - I thought you might be interested in the Katherine gap analysis.

MS ABRAMSON: Yes, absolutely.

PROF KING: Yes, we'll have a look.

MS GAWEN: Okay, will I give it to you?

PROF KING: Thanks for that.

MS GAWEN: Thank you.

PROF KING: All right, so I do have a statement to make at the end of the day. This is the last hearing, isn't it?

MS ABRAMSON: It is.

PROF KING: So in that case, seeing as there's no one else here that I can invite to give a presentation if they wished to, I will formally close the hearings of the mental health inquiries. Thank you very much.

MS ABRAMSON: And can we thank the staff for their hard work in organising all of this.

PROF KING: Thank you, staff.

MS ABRAMSON: Thank you.

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[4.13pm]