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

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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 receivance 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 form 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 ex0plained 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 form 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 ad 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 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 though 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 ad 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 want 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 got 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 to 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 it. 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 nursery 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, mid-wives, 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're 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 scare 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 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 you 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 has 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 it, 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 underserviced 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 stigmatise issue, 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 question 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 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 joints 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 stat 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 smoPROF KINGannabis', 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 sat 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 Magsitrate 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